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Village Doctors and Vulnerable Bodies: Gender, Medicine, and Risk in North India

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This dissertation tracks an uncommon migration: the movement of young women doctors from urban medical colleges to rural clinics in Rajasthan, North India. The ability for young women doctors to transfer their lives to a rural clinic, even for a year or two, is vital for career advancement in Rajasthan’s government health sector. Yet I found that women, over and over, rejected this opportunity, turning this urban to rural migration into a trickle rather than a flow. Through interviews, observations, and travel in urban and rural Jaipur district, I explore the meanings of urban and rural spaces as well as contested understandings of what role doctors should play in the health of the population. I found that rural spaces were discursively marked as particularly dangerous for doctors who are urban, middle-class women. First, moving to a “village of strangers” required shedding one’s protective social network and the paternalistic surveillance that accompanies it. Second, the presence of the wrong kind of men – lower class and rural – was seen to threaten urban middle-class women’s reputation and bodily integrity. Rural and peri-urban migrants were often blamed for the surge in sexual violence in India’s cities; for women doctors, moving to the village meant entering the origin point of these threatening bodies. The inability of women doctors to counter rural risk ultimately affects two groups of women: the doctors who find it necessary to turn down a village posting, thereby compromising their career in the government sector, and the patients who desire gender concordance in healthcare but find it unavailable in their area. My goal is to highlight the disconnect between the assumption, inherent in Rajasthan’s health policy, that women doctors can transport their lives seamlessly to village clinics, and the actual experiences of women doctors in rural work.
Village Doctors and Vulnerable Bodies: Gender, Medicine, and Risk in North India

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Dissertation
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CHAPTER 1
INTRODUCTION AND METHODS: WHY STUDY DOCTORS?

Introduction

The phrase *women’s labor migration* usually conjures images of people moving from “less developed,” often rural, spaces, full of poverty and empty of job prospects, to comparatively “more developed,” opportunity-rich cityscapes. This dissertation tracks a migration in the opposite direction: the movement of young women doctors from urban medical colleges to rural clinics. Women doctors do not move to escape poverty, but rather to seek a stable career in Rajasthan’s government health sector, and a potential boost in the competition for a coveted seat in a post-graduate program. The ability for young doctors to transfer their lives to a rural clinic, even for a year or two, is vital for career advancement in the government sector. And yet I found that women, over and over, rejected this opportunity, turning this urban to rural migration into a trickle rather than a flow. Unlike more visible flows of women migrating out of South and Southeast Asia to find jobs as housemaids, nannies, nurses, and garment workers (e.g., Gamburd 2000; George 2005, Lynch 2007) this small trickle has not attracted scholarly interest. This migration is mainly notable, after all, because it is hardly a migration at all. I argue that the movement of women doctors from city to village (or lack thereof) is worthy of our attention for several reasons. First, the reluctance of women doctors to migrate in this direction weakens the provision of women’s health care for much of India’s population. Second, the anxieties this reverse migration produces among individual women and their families shed light on gendered protectionist ideologies that shape women’s lives far beyond the medical field. This is ultimately an exploration of urban, middle-class gender norms and their reverberations across the countryside, crossing lines of geography and class.
This project began as an exploration of health care in India through the perspective of doctors. But why study doctors? Biomedical doctors are not an immediately obvious topic for ethnographic research in India: they do not live on the margins of society, nor are they “new” in any way. They occupy a position of dominance in health care delivery at the top of two hierarchies: commanding more resources than practitioners outside the biomedical system, and commanding more respect than nurses, midwives, and the other health workers that keep the biomedical system running. In this project I “study up,” not in the exact sense of Nader’s (1999) call to study the powerful in one’s own society, but as part of a project to interrogate power and inequality in health and health care globally (Farmer 1999, Pfeiffer and Nichter 2008, Singer 1995). In our post-Foucauldian era of scholarship, we have come to take it for granted that power is never clear, is enacted in diffuse ways, and is both restrictive and productive (Foucault 1980). I initially considered doctors to be subjects worth studying because they have considerable control over patients’ experiences in biomedical clinical spaces, but the space in my dissertation is largely filled with the ways in which women doctors do not have control over their work. Much of my scholarly energy has also gone into discourses of gender and space that shape doctors’ careers, and the role doctors themselves have in producing these discourses, particularly through their acceptance or refusal of rural postings. Ultimately, I argue that the study of doctors in India is productive in multiple ways. First, women doctors’ talk about risky places opens a window onto the urban middle-class discourse of feminine risk, and allows us to consider how this discourse stretches out to affect people seemingly unrelated to it (rural, lower-class women who are the potential patients of “missing” rural women doctors). Second, the neglect of women doctors’ problems in Rajasthan’s health administration shows us the intersections of class, gender, and health policy, where development discourse shapes “gender” as a term that can only
be applied to subaltern women and not to the women doctors who, already “developed” themselves, provide services to the rural poor.

A practical question intersects with these more theoretical arguments: why are women doctors missing from rural areas – and why does it matter? The majority of doctors, patients, and public health administrators I met during my research seemed to accept as natural fact that women medical practitioners are best suited to treat women patients, an idea I explore in the next chapter. In the gender-segregated social atmosphere of Rajasthan such an idea is not surprising. Without the basic assumption that women patients need women doctors, the shortage of woman doctors in rural areas would not be a problem; male doctors, for whom the shortage is far less dire, could do the work. If we accept that women doctors are necessary for women patients, then it follows that women doctors should exist in equal proportion to the population of women – not to bring gender equity to the field of medicine in order to advance women’s careers (although that would be welcome), but to provide for the female population of patients. In Rajasthan, where women’s health indicators such as maternal mortality repeatedly rank poorly in state-wise comparisons, increasing access to women doctors is a way to bring more women patients into the fold of institutionalized biomedicine. State health administrators therefore see women doctors as crucial agents of healthcare development – but, importantly, do not have specific measures in place to make rural work more acceptable to women. My focus on doctors, then, addresses the practical problem of women doctors’ rural avoidance, largely by looking to the way people talk about urban middle class women and risk.

I have also chosen to focus on doctors because I am concerned about the lack of access to emergency obstetric services in rural Rajasthan. If women doctors are hesitant to work in rural clinics, and the vast majority of obstetricians and gynecologists, or indeed any primary care
doctor with obstetric skills, are women, this creates a dangerous blockage in the system. I have a healthy distrust of the technocratic model of birth found in most biomedical hospitals (Davis-Floyd 2004), but I recognize the lifesaving capabilities of biomedical techniques. The birth of my own daughter began in a kiddie pool in the spare room of my apartment, with two midwives and a doula attending, but ended in the operating room of a hospital when complications arose. In my case the system worked exactly as it should: trained birth attendants saw something was wrong and whisked me to the hospital (a short five-minute drive away), where I had a successful cesarean birth. I worried about a million things throughout this process, but never about whether or not a team of surgeons would be in the hospital to help me. From a social justice perspective, the presence of life-saving obstetric care is a minimal requirement for a community to claim that women’s lives are valuable.

**Doctors in the Ethnographic Literature**

Doctors can be found in anthropological research on women’s health in India, but only if one peers into the ethnographic shadows. Anthropologists studying this area have gravitated towards marginalized populations with two main foci: 1) patients, especially those who lack financial resources or easy access to good quality health care (Van Hollen 2010, 2003; Jeffery et al. 1989; Jeffery and Jeffery 2010, 1993); and 2) birth attendants working both within and outside of the biomedical system (Pinto 2008, Price 2014, Rozario 2997, 2002). The patients we see in these ethnographies seek help for childbirth, family planning, and reproductive complaints from a diverse range of health workers, midwives, post-partum workers, family members, and professional biomedical practitioners. In their research on childbirth in the North Indian state of Uttar Pradesh, Jeffery et al. (1989) tell a story that sparked my interest in doctors. In this
narrative Patricia Jeffery convinces a hesitant birthing woman and her family to ride in her jeep to the district hospital during a prolonged labor. Staff refuse to admit the birthing woman until Jeffery tells them she is British; nurses chastise the birthing woman for her moaning (“is she a goat or a buffalo that she cannot suffer even light pains?”); and the doctor finally presents the news of a healthy cesarean birth to the father using a disrespectful form of address (Jeffery et al 1989, 116-117). The authors’ account is a harsh indictment of the provision of public health care in Uttar Pradesh. The hospital performed a lifesaving function at the expense of the couples’ dignity, and only when persuaded by the presence of a foreigner capable of wielding more social capital than the birthing woman.

Van Hollen (2003) presents a more complicated account of hospitalized childbirth in the South Indian state of Tamil Nadu. Doctors scold women for making noise during birth, but many women see this as evidence of doctors’ caring rather than abuse (Van Hollen 2003, 131-133). One doctor admits to brainwashing her patients into accepting contraception even if they initially object to it, and yet doctors “genuinely believed that they were helping postpartum mothers” as they tried to bring mothers’ behavior in line with biomedically-sanctioned practices (Van Hollen 2003:155, 169). This glimpse of doctors’ subjectivity further piqued my curiosity. How do doctors, the symbol (if not always the provider) of biomedical care, see their place in Indian reproductive health care? What insight might we gain in the provision of women’s reproductive health if we seek doctors’ perspectives?

My initial idea remained focused on the doctor-patient interaction. I planned to study the framing of this interaction during medical education, particularly how doctors are trained to see the bodies of their poor, female patients. During preliminary fieldwork in Delhi in 2010, however, I could not get any women doctors interested in this question. Instead they steered my
inquiries toward their more logistical work problems: how hard it was to do any work outside of women’s health, and how constrained they were by problems of travel. I began to hear how women doctors avoided rural postings in the government sector, often to the detriment of their careers. My project shifted away from doctors’ interaction with patients, moving toward doctors’ relationship to a spatial and a moral continuum: how did doctors relate to undesirable and “dangerous” rural spaces, and how did doctors frame their work as good for the community, no matter where they ended up?

Why Study “Women”?  

The “community” I studied across multiple sites does not fit the description traditional to anthropology; I did not find a group of people living in the same geographical space, or related by kinship or caste, nor does this group share the distinction of living on the margins of society. Yet doctors do share an important commonality that makes the category “doctor,” full of internal diversity, a salient one nonetheless: by virtue of securing a place in a medical college, each medical student or doctor has achieved something unreachable for the vast majority of the population. The social capital that adheres to a medical degree is common to the community of doctors. In other ways, however, the community is quite diverse. All levels of socio-economic and caste hierarchy are represented in the backgrounds of doctors, in large part because of caste-based reservations in higher education and government service. Doctors work in tiny one-room government clinics or multi-thousand-bed tertiary hospitals. Most consider themselves to be somewhere in the middle class, while a few are able to accumulate considerable wealth.

Further narrowing the designation “doctors” to include only “women doctors” presents another categorical conundrum – what, exactly, is a woman? One thing we can take away from
decades of feminist theorizing on this question is that “woman” is neither a natural nor a unitary category. According to Butler (1999), women are not born women but rather become so through a dialogic process of gender performance. Women are produced when those around them act as if they are female, while women simultaneously produce their female gender through the countless performances they do, day in and day out, thereby convincing themselves and others that they are, indeed, women. “Gender is the repeated stylization of the body, a set of repeated acts within a highly rigid regulatory frame that congeal over time to produce the appearance of substance, of a natural sort of being” (Butler 1999, 33). Furthermore, because the category “woman” is produced rather than predetermined, it is “open to intervention and resignification,” changing over time and space (Butler 1999, 33). Scholars and activists from the spaces of Black feminism and womanism (Collins 2000, Lorde 2007) and postcolonial feminism (Mohanty 2003, Oyèwùmí 1997), among others, have fought the idea that “woman” represents a cohesive and natural group.

From the perspective of gender theory, then, “woman” is a malleable category that is forever in production – but that does not mean that individual women are free to mold the category entirely to their desires. When the term “woman” is used to modify “doctor,” it assumes a convincing veneer of stability and naturalness; it also has a specific, (mostly) agreed-upon, social meaning. The “lady doctor,” as women doctors are called in Rajasthan, is a known category, marked off from the neutral “doctor” by women doctors’ assumed affinity for the delivery of women’s health care, an affinity contradicted by many women doctors without managing to shake off the persistent assumption. I use the category “woman doctor,” then, because it is a salient category in India, instantly recognizable as a particular, and marked, subset of doctors.
“Woman doctor” is the product of a discourse that excludes women from providing “regular” healthcare (for men) and keeps women doctors ghettoized in the realm of care for other women. This discourse is also exclusionary in that it reifies the male/female binary, leaving room for no one else. While the idea that women doctors are needed to treat women patients has come to be taken for granted by many, there has been no similar call for hijra doctors to treat hijra patients. Hijra is a socially recognized, yet widely discriminated against, third gender category in South Asia, the most visible of a range of non-binary gender categories (Hall 2005, Reddy 2005b). Hijra activists throughout South Asia have worked to codify the hijra gender as a third gender on official paperwork, enabling them to exist, according to the government, as people other than “male” or “female” (Hossain 2017, Khaleeli 2014). But, because hijras face forceful discrimination in the realms of higher education and work, “hijra doctor” is, for now, an oxymoron. A hijra who attempted an MBBS degree (but dropped out because of harassment) was remarkable enough to warrant a story in a Calcutta newspaper (Ramashankar 2014).

The “woman” category also carries the connotation of compulsory heterosexuality (Rich 1980). When I asked unmarried medical students if they planned to get married, the question was met with laughter or outright shock – of course they will get married, to a man. Heterosexual marriage, most often arranged by one’s parents, followed by motherhood, were naturalized requirements of middle-class womanhood (Donner 2008, Puri 1999). Many women medical students and doctors had an ambivalent relationship to marriage. Marriage was likely to curtail some of their freedoms, especially at first. At the same time, as I show in the dissertation, the sense of security offered by marriage could ultimately widen the geographic range of doctors’ potential work sites. Marriage could also, ideally, provide companionship and romantic love, or
it could bring friction and isolation to a doctor’s social world. Ultimately, no matter what meanings an individual doctor attributed to marriage, there was no clear path for opting out.

**Traveling as a Method**

Space figured prominently in my research for several reasons. First, because the decision to take a rural posting was often fraught with ambivalence, doctors participated in the creation of spatial discourses of “the village” and “the city” as they planned their futures. In addition, women worried about how to move through public space safely, and worried about how to translate the rules of urban middle-class feminine comportment to the space of the village. When I brought up traveling, interviewees often deftly turned the tables on my questioning, wanting to know what kind of rules structured my own movements through space as a woman, and a foreigner, living in Jaipur and traveling to the countryside. While I had not been to medical college or worked as a doctor, traveling around the city and to the interior was something we had in common. I focused my inquiries on shared imaginings of space as well as on individual women’s narratives about their experiences in the city and the interior.

My arguments are informed by my own experiences traveling throughout the city and countryside as a woman. The anxieties I experienced were my own, but I heard enough echoes of them from my informants to know that gendered worries were not simply the result of my being in a foreign place, unsure of how to respond when men rubbed up against me on the bus or stared at me relentlessly. In fact, my anxieties only grew as I was more and more exposed to the culture of female protectionism that permeates Rajasthani culture. Not everyone I talked to experienced the kind of anxiety I did, and of course no one would have experienced it in quite the same way. I have tried to document some of these experiences along with the larger cultural narrative that
shapes the way women are able to move through space in bodies that are deemed in need of male protection.

Some of the clearest memories I have of fieldwork are those of following the paths of doctors: riding in buses across the city and through the countryside, returning repeatedly to a clinical site only to find the person I was looking for absent. The story that best encapsulates the frustrations of “traveling as method” happened during my first stay in the village of Vijaynagar where I rented a room to have easier access to nearby villages. On a Saturday morning in February I walked from my room to the highway, climbed into the back of a jeep that was pleasantly warm from the body heat of the other passengers, paid five rupees (seven cents) to the driver and emerged at Krishnapura Primary Health Center seven minutes later. I had arranged with Dr. Nandini, the medical officer, to observe the morning shift at Krishnapura Primary Health Center and then interview her during her lunch break. When the break came at one p.m., I found myself running alongside her as she hurried to the bus stop to go back to Jaipur, leaving no time for my interview. She asked if I could meet her the next evening in Jaipur. So, after spending only one night in Vijaynagar, I made arrangements to take the bus back to Jaipur the next day. When I called Dr. Nandini from my Jaipur apartment that afternoon she changed her mind, telling me that it wasn’t safe for me to come, alone, to her parents’ house after dark. Could I meet her the next day back in Krishnapura? Yes, of course. The next morning I got back on the bus to Vijaynagar, dropped off my belongings, rode the five rupee jeep to Krishnapura, and got my interview. All of this traveling initially seemed like a pointless frustration but came to be an important part of my research itself. Knowing how cities were connected to villages, and how villages were connected to each other, and what it was like to move between these spaces as a woman, was worthwhile data. Traveling itself became a method of collecting information that
may not have seemed useful at first, but came to shape my understanding of doctors’ mobility in meaningful ways.

Anthropologists have become increasingly willing to question the traditional requirement of long-term fieldwork in a single community, especially as our theoretical and practical questions take us further into the realm of movements and flows of people, objects, and capital, and away from the “old ideas of territorially fixed communities and stable, localized cultures” (Gupta and Ferguson 1997b, 4). My “field” was not bounded by a neighborhood or geographically-defined community; instead it required me to understand the relationships between geographically distant spaces (Hannerz 2007). Chasing down the meaning of rural work for women doctors required me to follow women doctors to far-flung sites and to understand the daily lives of doctors in the city. I began my research in a medical college, talking to students and doctors about their relationship to rural work. At the same time, I tried to find women doctors who were actually working in villages, a task that presented a number of challenges. The shortage of women doctors creates an obvious methodological problem, in that the population I was trying to study was one recognized to be small. By calling upon contacts I had made in urban Jaipur, I was able to meet women doctors in six different rural clinics (I visited a seventh rural clinic with two doctors, a man and a woman, but was only able to interview the male doctor.) Aside from two week-long stays in the village of Vijaynagar, I did not live in the immediate vicinity of any of these sites. I studied the idea of village work more than the nitty-gritty of the work itself, and this allowed me to be in the city, where young doctors exchange stories about village work and government health planners craft policy. Living in Jaipur for two nine-month stints (first for language training, then for research) proved critical to my understanding of the research problem. I learned what kinds of amenities, available in the city,
are missing in the village, and how important those amenities are to the performance of class status.

Once my research turned to the problem of doctors’ mobility, my own mobility became an important research tool. Part of what has separated anthropology from other social science disciplines has been the imperative to travel from one’s home place, following in the footsteps of a long lineage of people, mostly male and Western, missionaries, colonial officials, and writers (from whom anthropologists were eager to differentiate themselves as “scientists”) (Clifford 1996). While travel to the field is common, travel within the field as an integral part of data collection is slightly less so (with some notable exceptions, such as pilgrimage studies; e.g. Gold 1988, Singh 2017). Traveling took up a large percentage of my time. To get to Mahatma Gandhi Medical College, one of my most-visited research sites, from the apartment I shared with my husband, I walked one-and-a-half kilometers to the bus stop, then waited alongside one of Jaipur’s main thoroughfares for the bus to take me to the edge of town. As the grimy pink bus (color coded by route) approached, I would squint to see the letters written by hand on the windshield to make sure it was going as far as I was. Then, along with a few other people, I would start jogging towards it, eventually stepping alongside to jump into the rear door well as the bus slowed but did not stop. Once inside, I scanned the seats at the front, marked with signs that reserved them for “mahilayen” (women) only. They were always full, and as likely to be occupied by men as women. Occasionally I saw older women approach men sitting in these seats to claim them for themselves; they rarely succeeded. I never saw a young woman attempt this.

Riding public transport in and around Jaipur taught me that, as a woman, especially a foreign woman who stands out, it is better to be as invisible as possible. I learned to shrink in on myself. I had long stopped the culturally inappropriate practice of smiling at strangers, especially
when strangers were men, offering them (unbeknownst to me) an open invitation to “make friendship,” an English phrase used by Hindi speakers to refer to a romantic or sexual relationship. I began looking at the ground as I moved through space to avoid making eye contact. I learned from my acquaintances that, as a white woman (and therefore recognizably Western), I was a special target for men looking for a sexual relationship. Men passing by on a motor scooter would yell “fuck me!” as I walked down the road, which I initially read as an insult. Then I began to hear a different inflection: “fuck me?,” which made more sense: it was a proposition, most likely made in jest as they rode by, but unsettling still. I decided to cover my head in the fashion of young women traveling to school or work, wrapping a thin cotton scarf around my face and tying it on the crown of my head. I began wrapping my face this way in the winter and thought I could see a decrease in harassment on the bus and the street. But when the heat came in March, and my pale bare arms emerged from their protective sweater, the harassment picked back up.

Riding the bus changed my relationship to space in the city. On the one hand, I found freedom that I had not encountered before, when my wanderings were confined to the neighborhoods surrounding my apartment, plus an occasional trip into the Pink City, Jaipur’s oldest market area, by auto rickshaw. On the bus, Rs. 15 (around 25 cents) could take me to the very edge of the city, a place I had never ventured before. On the other hand, I felt newly vulnerable to the male gaze, and to my out-of-placeness in the city streets, even as I moved with efficient purpose on routes traveled by other women. We were all trying to be a little less visible under our head wraps. An incident later in March, where a young man grabbed my breast as I boarded the city bus, offered a way for me to broach the topic of gendered harassment in public space with medical students and doctors. I asked if things like this happened to them, and what
they thought the appropriate response should be. A few women were shocked and horrified, saying this had never happened to them, and it was probably a result of my foreignness. Others accepted it with resignation, saying this is just what happens, and giving me advice about how to lessen my risk: don’t go out after dark, bring a friend, bring your husband with you.

The ethnographic challenge in following these rules is that all social life in Jaipur city happens after dark. One night I took an auto rickshaw to have dinner at the house of a mother and son who were both doctors. The mother, tired after a long day of working, began cooking without any great haste. I sat on the floor of her kitchen while she worked, my offers to help repeatedly rebuked. A feast with multiple dishes (nothing like the one-pot meals that count as dinner in my working-parent household back home) materialized around ten p.m. Then, after dinner, there was
the problem of how to get home. My friends called an auto rickshaw driver with whom they have a relationship and convinced him to take me far out of his neighborhood. When I got home, I found the gate of my apartment complex locked from the inside. I could see the guard on the floor of his shack, sleeping contentedly. I tried to wake him without yelling too loudly, thus calling attention to my predicament as a woman locked out of her house. The solution came to me: I could easily scale the wall of the fence to get inside. The elaborately locked gates took on a new meaning once I saw how easy they were to get around. They sent the message that this was protected domestic space, reinforcing the idea that there were dangers beyond the gates, and that I should be safely tucked away inside by the time they closed.

The tension between needing to go out at night to participate in social events, and being told over and over that women should not be out after seven p.m., reinforced for me the necessity of a social network. For women, a rich social life requires friends and relatives with whom they can get around the city. My situation as a woman traveling alone at night presented difficulties that most urban doctors, who lived communally in hostels or with family, did not face. Experiencing these restrictions myself allowed me to better understand the loneliness that awaited women doctors in a village setting, a topic I explore in Chapters 4 and 5. When doctors described village locations as desolate they were referring to the social landscape as much as the built landscape. Absent the group of friends or family members that greatly enhance mobility, women doctors could experience spaces outside the city as both frightening and socially impoverished.
Research Sites: Jaipur City

Jaipur, the capital of Rajasthan, is a city of three million people. Medical students emphatically asserted that Jaipur was not a “metro” like Delhi or Mumbai, Indian cities deemed more modern and global (and home to approximately 18 million people each). For some, this made Jaipur more desirable – it was less dangerous and less daunting. For medical students who came from Delhi, Jaipur felt a bit like a backwater. Living in a large city made my entry into the field fairly simple, as life in Jaipur was similar in many ways to life in the States. I lived in a three-bedroom, two-bathroom apartment (far nicer than anything I could afford back home) in an upper-middle-class high-rise building. We had indoor plumbing, hot water heaters, and a generator that would work the fans when the electricity cut out. I chose the apartment for the housekeeper who came with it, rather than for its location – far from the bus station, my point of departure for rural trips, and far from Mahatma Gandhi Medical College, where I spent much of my time in the city. My inconvenient location was to shape my research in critical ways as I was forced to negotiate transport around the city. Suman, my motivation for taking the apartment, cooked dinner for us on weeknights and cleaned the apartment. Gyani, a lower-caste woman who also worked for many apartments in the building, cleaned the bathrooms. Suman, a member of the higher Rajput caste, would not even set foot in our bathroom. I initially balked at hiring someone to do this demeaning job, but Suman, who saw herself as a champion for Gyani’s well-being, saw it differently – how could I keep my American dollars to myself when Gyani so clearly needed them?

I first met Suman in the summer of 2008 when I came to Jaipur to study Hindi. The apartment was passed down from student to student in the Hindi program, usually occupied by men who had a more difficult time finding families willing to house them in homestays (if
families had daughters at home, they did not want strange men in the house). The man who later became my husband, Drew, stayed in the apartment that first summer and introduced me to Suman. She was a loud, assertive presence in the house, in the best possible way. When she burst in the door she immediately became the center of attention, shouting hello, swaying her way to the kitchen, flailing her dust rag haphazardly at surfaces. She liked to slap me on the shoulder with great affection and force, saying “Didi!” (older sister) and smiling conspiratorially. When I moved into the apartment myself for a year-long Hindi program in 2012-13, as a now-married woman, I was allowed into Suman’s world of dirty jokes and lewd gestures. I could not buy any cucumber-shaped vegetable in the market without her silently-mimed commentary on the phallic nature of my purchase, followed by deep laughter and more slapping on my shoulder. I write a lot in this dissertation about how families seek to control women’s movements, but it does not follow that Indian women must be meek or demure (see also Puri 1999, Raheja and Gold 1994). My relationship with Suman was a daily reminder of the utter inadequacy of the “third world woman” stereotype to portray women’s lives in Rajasthan (Mohanty 2003).

The urban site where I spent much of my time was Mahatma Gandhi Medical College (MGMC), part of Mahatma Gandhi Hospital. MGMC opened in 2003 in an industrial park on the edge of Jaipur’s city limits. MGMC is a private hospital and college, part of a trend in medical education in India that capitalizes on incredible demand for medical college seats. The attached hospital attracts some patients from the semi-urban periphery around Jaipur, but its desolate location places it far away from any residential area that could easily draw patients. I also visited MGMC’s satellites, an Urban Training Center in a neighborhood outside of the industrial park, and a Rural Training Center in Vatika, a nearby village. Other private clinical sites where I recruited participants are: Ratna Hospital, a five-hundred-bed tertiary facility; a seven-bed
“nursing home” providing maternity care to residents of a nearby migrant neighborhood; and three in-home obstetric/gynecology offices.

Jaipur’s largest and arguably best-respected hospital is Sawai Man Singh (SMS), a government hospital in the heart of the city. I outline my difficulties in gaining access to SMS below, but I did manage to interview seven students at the college. I also visited two government-run primary health clinics. Urban sites in the government sector provided an important window onto rural work because many of the doctors who had “made it” to urban government hospitals had experience working in a village. It was methodologically far more efficient to track former rural doctors down in the city than it was to search for them in the countryside. Of course, hearing stories of the village from returned doctors was not the same as experiencing the village for myself, and meeting doctors who were in the midst of rural work. In the next section I outline the sites that comprised the rural segment of my research.

**Research Sites: Villages**

I entered the space of the village timidly at first, not knowing exactly how to find women doctors. A doctor at MGMC told me about the large village of Vijaynagar, easily accessible from the highway, which became a sort of “gateway” village for my research in rural Jaipur district. For my first trip to Vijaynagar I hired a driver, Suryavanshi, through a taxi service, paying a high price by the meter. Once Suryavanshi found out what I was up to, he gave me his mobile number and began carting me around the countryside in his own car for a slightly cheaper hourly rate. He ended up helping me tremendously, introducing me to doctors in Dausa district where his wife’s family lived. All of my trips in Dausa were facilitated by Suryavanshi and his female relatives (who also served me rotis the size of dinner-plates dripping in fresh butter provided by their own
buffaloes). Once I became familiar with the rural sites in Jaipur district, I traveled there by bus – a far cheaper research method. Riding the bus into the dehat, or countryside, was not something city folk did much, unless they had relatives still living in a village. The bus stops were never announced; everyone assumed that if you were going to jump down on the side of the highway at a particular village, you knew that village and where it was. This is one of the many ways in which a typical urban-raised doctor is an outsider when she leaves the space of the city.

My rural travels included seven clinical sites: five in Jaipur district (within two and a half hours of the city) and two in neighboring Dausa district (between three and four hours from Jaipur). Four of the sites were Community Health Centers (CHCs), hosting medical officers and specialists along with a wide range of other facilities, including (sometimes) a lab, a maternity ward, an operating theatre, and a dentist. The other three were Primary Health Centers (PHCs) with one or two medical officers and two to three other staff members. Krishnapura was the smallest PHC I visited, hosting one doctor in a small square concrete building. Dr. Nandini, the medical officer at Krishnapura, mostly performed triage in her role as a primary care doctor. She prescribed drugs for minor ailments such as coughs, colds, and intestinal infections. If she was unable to diagnose the patient’s problem based on a one-minute long consultation conducted in full view of the other patients waiting to see her, she would refer the patient onwards through the system – either to the closest CHC or to the district hospital. PHCs were open for about four hours in the morning, followed by a three-hour lunch break, followed by two to three hours in the afternoon. Doctors were expected to live as close to the PHC as possible so they could be available for emergencies during their off-hours. Doctors who were settled in the village and had made a name for themselves could also maintain a private practice during these hours.
Most rural clinics in the government sector provide living quarters for their doctors to ensure that doctors will remain onsite. Of the twenty-one women I interviewed who were formerly or currently working in rural clinics, none were willing to live in the clinic’s quarters without the presence of other women residents. Dr. Nandini of Krishnapura solved this problem by commuting, referred to by doctors in English as the “up-down,” living with her parents in Jaipur city and riding the bus daily to Krishnapura. The message of risk that attached to living alone came from families, who were responsible for the young woman’s safety, and from young doctors themselves, many of whom had tried, and then abandoned, living in rural hospital quarters. Medical students who had yet to experience life in the village knew less about specific dangers than their older colleagues, but they still were well-versed in the narrative of risk, telling me that rural postings were dangerous for women.

Figure 2: Suryavanshi’s wife’s relatives in Dausa district

Urban-raised doctors had a hard time imagining their lives in a village, and I had similar apprehensions about rural fieldwork. I had chosen a city for my research, after all, only to be pulled into the rural interior by questions I had not initially intended to ask. I arranged two short-
term stays in Vijaynagar to get a better feel for village life. I spent the first night alone and shivering in a giant bed; my presence had evicted the family from their shared bedroom into the spare room to sleep on mats on the floor. I lay awake plotting out the steps I would take if I needed to use the pit toilet in the dark (thank goodness I remembered to bring a flashlight).

Things that were normally simple, like turning on the light switch or flushing the toilet, had to be worked around with great anxiety. In the morning I wandered into the main room and looked out the window (a glassless opening in the wall protected by metal bars). In Jaipur, the heat would already be radiating from sun-baked asphalt and traffic; here was cool mist rising off the wheat field behind the house. Birds chattered. There were trees –green trees instead of brownish and dusty and stunted by pollution. “Aha!” I thought – there are benefits to living in a village. But enjoying the rural greenery during a quick respite from the city and actually living in the village were two very different prospects. While I appreciated the beauty of Vijaynagar’s landscape, imagining the kinds of adjustments I would have to make to live there long-term was daunting.

Prema, an elementary school teacher whose husband worked at Vijaynagar CHC, was my landlord in the village. She and her husband lived “separately” (in a nuclear family) with their two young sons. Prema was a wonderful source of insight into local rules of gender segregation, as she had grown up in South India where, she told me, couples went out together in the evenings to have fun. In Vijaynagar, the kind of companionate marital outings Prema had seen in the South were scarce. She did not socialize in the presence of her husband; indeed, there was nowhere in Vijaynagar for couples to go. Prema also found the requirement to cover her head and face in the presence of her husband’s relatives strange and unwelcome at first, although it came to feel natural to her over time. I found a kindred spirit in Prema because we were both newcomers to Vijaynagar, albeit under very different circumstances. Prema was also intrigued
with the way I interacted with village residents. One afternoon, while walking home from the Vijaynagar CHC, a group of middle-aged men stopped me to ask what I was doing in the village. I explained my research, and they began to tell me about the shortage of lady doctors and how this is a problem in many communities. The conversation ended after a few minutes and I carried on home. Prema came in the door right on my heels with a lot to tell: she had spotted me talking to the men but couldn’t say anything at the time; that would have drawn attention to her presence in front of men around whom she must be veiled and demure. After I left the middle-aged men, Prema, following a short distance behind me, spied a group of young men staring at me from their motorcycle. She yelled at them for their audacity while I walked on completely oblivious. This rather eventful walk home illustrates the difference in our social positions in the village: I could easily converse with important men in the village, while Prema had to pretend she was invisible to them; at the same time, Prema had no trouble scolding a group of young men for disrespecting her friend (something I was always hesitant to do).

**Interviews and Observations**

Most of my data comes from 80 semi-structured interviews. Doctors are familiar with the formal interview as a research tool, having used it themselves to collect data in Preventive and Social Medicine classes. This familiarity meant that many medical students and doctors expected the interview to follow a particular path: I would read standardized questions from my list, and they would give the “correct” answers. Some doctors shifted easily to my more conversational tone, but others balked at my difficult and open-ended questions; how could they know what the correct answer was? When I kept returning to the medical college to seek the rapport that is so elusive in a busy hospital, others asked me, over and over, “what are you still doing here?”
thinking my “survey” should take a few weeks at maximum. Traditional ethnographic research requires a critical mass of people who are hanging out, or at least doing work over which they can talk, for a good portion of the day. Doctors at MGMC had no time for me. They tolerated my presence, supported with a signed letter from the principal, but they did not take me under their wing in the way I had hoped. Instead I attached myself to cohorts of medical students who allowed me to follow them around as they traveled from the outpatient clinic to the maternity wards in search of a professor to guide them in the day’s activities. As often as not, they gave up and returned to the hostel to study.

I finally found the people who were as curious about me as I was about them, meaning they would make time to let me into their lives, in the last two months of my fieldwork. At the same time the *loo*, the hot wind from the desert, rolled in, slowing the pace of life dramatically. A medical student who had invited me to visit her grandparents’ village with her decided it was too hot to go, and I agreed. Riding the steaming bus from city to village took more and more energy with each passing day. Overhead fans on the highest speed competed for sound space with my informants’ voices on interview recordings. Excitement over getting good data kept me going, and I rejoiced at finally being invited into people’s homes, crossing over some previously invisible line from “survey” into ethnography. This victory was hard won, doubly difficult to achieve due to the hospital’s bustling atmosphere and the scattered geography of the research sites I had chosen.
<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mahatma Gandhi Medical College (MGMC)</td>
<td>Large private tertiary hospital (1000 beds) with medical college; peripheral location</td>
</tr>
<tr>
<td>Ratna Hospital</td>
<td>Large private tertiary hospital (500+ beds) with residency programs; central location</td>
</tr>
<tr>
<td>Nursing home</td>
<td>Small in-patient clinic (7 beds) for maternity care; central location</td>
</tr>
<tr>
<td>Private practice in home (three sites)</td>
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</tr>
<tr>
<td>Sawai Man Singh Medical College (SMS)</td>
<td>Large public tertiary hospital complex (6000 beds) with medical college; central location</td>
</tr>
<tr>
<td>Urban dispensary (two sites)</td>
<td>Small outpatient clinic; central location</td>
</tr>
<tr>
<td>Vijaynagar</td>
<td>Community Health Center</td>
</tr>
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<td>Raigarh</td>
<td>Community Health Center</td>
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<tr>
<td>Jivanpura</td>
<td>Primary Health Center</td>
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<tr>
<td>Jyotipura</td>
<td>Community Health Center</td>
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*Table 1: Occupational Sites of Interviewees*

Participant observation during long-term fieldwork has been the cornerstone of anthropologists’ methodological pride for most of the history of North American anthropology, separating anthropology from other disciplines in the social sciences and humanities (Gupta and Ferguson 1997b). The kind of participant observation that I had imagined myself doing, where I would become a fixture in a clinical setting, known to everyone and hopefully welcomed, did not ever materialize into reality, in large part because of the multiplicity of field sites that made up my project. Gupta and Ferguson address the tension between the insistence on long-term participant observation in a single place and the theoretical rejection of stable meanings of the “local,” infused into anthropology in the post-modern era. My project asked about the movement
of people, and the meaning of one place (the “village”) as it was produced in another place (the “city”). Where, then, was the local community I should be sitting to observe? As Clifford writes, while multi-sited research is more and more acceptable, “multi-locale fieldwork is an oxymoron,” where fieldwork constitutes “a spatial practice of intensive dwelling” (1996, 6; see also Marcus 1995). Yet, as Hannertz (2007) points out, anthropologists have been following their subjects for a long time – even Malinowski followed the Trobriand Islanders on their kula journey – despite relative silence surrounding this practice until an interest in theorizing space and place blossomed in anthropology in the late 1990s (Gupta and Ferguson 1997a, Gupta and Ferguson 1997c, Low and Lawrence-Zúñiga 2003). By the time I write this, multi-sited ethnography is no longer a fringe practice; at the same time, the tension between long-term participant observation and the very different imperatives of my multi-sited project left me feeling like I was not quite doing “proper” ethnography. I can easily find theorists to back up my methods, but the affects cultivated in me during graduate training that made long-term sitting in one place feel more like real ethnography are more difficult to dislodge. In the end I persevered with my “traveling as method” because it seemed like the best way to answer my particular questions.

In addition, I found that participant observation “is a research technique that does not travel well up the social structure” (Gusterson 1997, 115). Those in positions of institutional power can easily deny access, with no repercussions, to researchers hoping to observe them. Instead of the traditional method of participant observation, Gusterson argues for the use “polymorphous engagement” when studying up, a technique that “preserves the pragmatic amateurism that has characterized anthropological research” while anthropologists interact with informants “across a number of dispersed sites, not just in local communities, and sometimes in
virtual form; and it means collecting data eclectically from a disparate array of sources in many different ways” (Gusterson 1997, 116). I was able to observe some clinical spaces, such as the maternity ward at MGMC and the outpatient hours in several rural clinics. However, I never managed to gain the status of “participant” in these spaces. I was more of an anthropological fly on the wall, catching glimpses for an hour here or fifteen minutes there, tacked onto the beginning or end of an interview. I found it very difficult, particularly at MGMC, to explain the merits of participant observation in a way that satisfied doctors, who seemed less concerned about an outsider witnessing the inner workings of the hospital than they were dismissive about what observation could possibly contribute to my project. The challenges of access in biomedical institutions, along with the bureaucratic challenges I describe in the next section, nudged my project towards “polymorphous engagement” with students and doctors in spaces outside of their clinics: in their homes, on the backs of motor scooters, at the chaat [a kind of snack] stand outside of MGMC, and on Facebook. I also became more willing to accept the idea that my own travels on the city bus and in rural jeeps were data that could tell me something worthwhile about doctors’ relationship to space.

Feminist ethnographers find ourselves in a difficult place as we try to represent our interlocutors faithfully while at the same time protecting their privacy and, in this case, their jobs (Stacey 1988). I have taken care to protect, to the best of my ability, the identity of the medical students and doctors who participated in my project, particularly in the case of government employees. While women doctors’ rural avoidance is a fairly benign topic, it brushes against more controversial themes, such as corruption, discrimination, and inadequacies in Rajasthan’s health care system, that doctors may not want associated with their name. To this end I have used pseudonyms for all named people who appear in this ethnography (unless otherwise noted). In
some cases I have modified personal details that may have made a doctor recognizable to their colleagues – while still, I hope, remaining faithful to their story as I understand it.

<table>
<thead>
<tr>
<th>Position</th>
<th>Number of Individuals</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>Medical intern</td>
<td>12</td>
</tr>
<tr>
<td>Postgraduate student</td>
<td>15</td>
</tr>
<tr>
<td>Obstetrician/Gynecologist</td>
<td>9</td>
</tr>
<tr>
<td>Medical officer</td>
<td>4</td>
</tr>
<tr>
<td>Pathologist</td>
<td>1</td>
</tr>
<tr>
<td>Hospital administrator</td>
<td>1</td>
</tr>
<tr>
<td>Public health official</td>
<td>5</td>
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<td><strong>Total interviews:</strong></td>
<td><strong>80</strong></td>
</tr>
</tbody>
</table>

Table 2: Interviews by Occupational Position

**Access**

In addition to the challenges of multi-sited research, medical anthropologists have found the methodological requirement of long-term participant observation to be notoriously difficult in biomedical institutions with many layers of gatekeepers and the thorny issue of patients’ privacy (van der Geest and Finkler 2004). I spent a far greater proportion of time chasing down access than I had anticipated; these bureaucratic frustrations dominated my entry into the field. During the previous year while I was in Jaipur for Hindi language training, I approached two medical colleges: MGMC (private) and SMS (government) for permission to do research. At MGMC, I was able to get an immediate meeting with the college’s principal. Stone-faced, he read my research protocol while I sat nervously across his desk. By the end of that meeting I had verbal permission for my research, and after two more trips to his office over the next couple of weeks, I had a signed letter on college letterhead allowing me in. The process at SMS could not have
been more different. I first approached the director of the obstetrics and gynecology department where I hoped to do observations. She passed me along to the principal of the college. From there I met an administrator who advised me how to submit my proposal, which I followed along as it made its way through various departments. After a month of regular visits to see how it was coming along, I met a young administrator who asked for my phone number, telling me he would call me in a few days to let me know the status. He called me that night, six times. When I finally called him back, he had nothing new to tell me about my proposal. He did, however, want to know if I was home and if I lived alone, since he was hanging out in my neighborhood and wanted to meet up. After I told him that I lived with my husband I never heard from him again.

After many more return visits, unsure of exactly what was happening with my proposal, a letter emerged from the obstetrics and gynecology department just before I left to return to the States for the summer. It listed five requirements for research access: I had to 1) deposit the necessary fees required by the government; 2) get permission from the principal; 3) get permission from the college’s ethics committee; 4) work under the guidance of the head of obstetrics and gynecology; and 5) run everything past her before publishing. I considered this a win – at least I had concrete goals to work toward. When I returned to Jaipur in the fall I found a research sponsor in the Preventive and Social Medicine department at SMS (another requirement that was added on) and began the process of submitting to the ethics committee. Although I found a professor willing to sponsor me, I was later told that she could not be my sponsor because I was not an SMS student; as a non-student of the college I could not, therefore, do research there. The ethics committee came to a similar conclusion. I presented my case in front of a two-member screening team and then the full sixteen-member committee. Nearly the entire committee found my project scientifically lacking, including the one woman who agreed that
women’s rural avoidance was indeed a problem worth studying. The doctor who seemed to be in charge reigned in the discussion of my methods, saying “We are not here to decide whether or not her project is good; we are here to decide if it is ethical.” Ultimately my list of interview questions, which I had deemed innocuous, was the deciding factor in their decision to deny me research permission. Included in my list of questions for medical students and doctors was the question: “what is the role of the state in health care?” One doctor told me this was a dangerous question and I should not be asking it. Another doctor brought up the danger of allowing a foreigner to take data about India back to their country. I cannot disagree that, from the perspective of the state, asking doctors about the state’s role (especially during increasing defunding of health care) could pose a risk. In addition, their discussion about the data I would be taking out of India to publish in widely available American venues brought up important issues of power and control over information. As they correctly surmised, I was likely to tell a story about the provision of health care in Rajasthan that was unflattering to the government.

This story – of easy access to the private college and blocked access to the public college – tells us something beyond the difficulties of government bureaucracy. First of all, my whiteness was important in both cases. When I approached the president’s office at MGMC, the president’s gatekeeper ushered me in without question. He could tell at a glance that I was a foreigner and may have assumed I was much more important than I, a mere graduate student, actually was. At SMS, my foreignness/whiteness did not let me bypass the thick crowd of gatekeepers protecting the administration. In the end, it was this foreignness that swayed the ethics committee’s decision to reject my proposal. I began to suspect that the bureaucratic hurdles piled before me were impossibly contradictory on purpose to deal with my inconvenient presence. When I persevered in trying to work around them, I found my phone calls to
previously helpful people beginning to go unanswered. In the end, I was a person of little importance to the workings of the college. Turning my project down would have no adverse effect on anyone save me, the outsider. Saying yes to my project, however, carried real risks should my published results reflect negatively on SMS. Had I been associated with a powerful figure in the government health administration I think my case could have been more compelling (as Ruddock (2017) argues of her entry into a government medical college in Delhi).

While my outsider status blocked me from access to SMS, it helped me in other locations. I made a cold call to meet doctors at one of Jaipur’s larger urban dispensaries, hoping to find a woman doctor on staff. Sure enough, the “lady doctor,” Dr. Asha, was in, and a nurse directed me to the room where she was seeing patients. She was not expecting an American researcher, yet she knew immediately that I was there for something other than my own health. When she looked up to see me waiting on the bench while she saw patients, she immediately apologized for keeping me waiting: “Oh, sorry, I didn’t see you there!” I was a foreigner, and therefore of high enough class status that no one would expect me to visit this clinic for health care – I must be there for some other reason. Doctors seemed to find me more out of place the further I went from urban tertiary hospitals such as MGMC. My foreign status did not guarantee access in every rural setting – some doctors seemed happy to have me around, while others were suspicious of my intentions or were made uncomfortable by the presence of an outsider, and they limited the kind of access I could have.

**Language**

I interacted with doctors in a linguistic potpourri of Hindi and English. As English is the language of instruction in Indian medical colleges, medical students and doctors had, at
minimum, a large English vocabulary. Conversational fluency, however, varied widely among my interlocutors. I had to decide at the beginning of an interview whether or not I would introduce myself in English or Hindi. Unless I already had clues to a person’s comfort in English, I chose to begin with Hindi; the student or doctor could then switch to English if she chose. Just under forty percent of interviewees spoke Hindi for the majority of the interview. MBBS students tended to prefer Hindi, both for interviews and hanging out in dorm rooms (MBBS students usually spoke Hindi amongst themselves as well). Post-graduate students and specialist doctors were more likely to switch to English.

Although I preferred to use Hindi if doctors were not comfortable with English, sometimes English was the only option for social reasons. English carries great social capital in India, and because doctors are supposed to know English, it was clear that some felt compelled to use it even though they lacked fluency. I conducted a very brief interview with Dr. Hema, a public health official, in her office while one of her coworkers was coming in and out of the room. When the coworker was present, Dr. Hema answered my questions in tentative, barely audible, English. As soon as the coworker left, Dr. Hema began answering in Hindi, only to switch back again when the coworker reappeared. My experience with Dr. Hema was echoed in several other interviews, although never quite so dramatically. The fact that a handful of interviewees forged ahead in English despite struggling with it suggests that they see an interview with an American researcher as a social situation requiring the language of professional medicine.
Who Should Work in the Village?

I began my training in medical anthropology thinking mostly about patients and issues of health care access. Although my research approaches access from the subject position of women doctors, patients are ever in the back of my mind. Studying up never really takes the focus away from those at the bottom of the hierarchy; instead it is a mode of inquiry that attempts to gain a fuller understanding of the entire system. When I think about women doctors taking rural postings, in the back of my mind rests the assumption that they should, that this work is necessary for women patients to get the care they need. Fassin urges us to “consider the anthropologist’s own moral prejudices – or in a more neutral way, value judgments – as objects of his [sic] scientific investigation as well as those of his ‘others’” (2008, 337). From where, then, does the assumption that women doctors should make this sacrifice come, and how might it affect my portrayal of doctors? I see two strains of thought informing this position. One, that I am happy to embrace, is an emphasis on equalizing opportunity – in this case, the ability for marginalized women to access high quality, holistic health care. A second, that makes me uncomfortable to think about but is therefore all the more necessary to interrogate, is tied up in ideas about exactly who should work in villages. It seems most practical for women who come from a particular region to return to that region to work, especially if it is underserved in terms of health amenities. But this idea cannot be divorced from the idea that village work means taking a step back in living conditions and one’s social world. I had a hard time living comfortably in a village, and yet my project implicitly asks that Rajasthani women live and work in villages despite these discomforts. What right do I have to ask these women to pick up their lives and move to what they call a “backward” place, other than the power inherent in being the one who tells their story? This project could read as follows: from the comfortable standpoint of the
American academy, I am trying to save the bodies of poor Rajasthani women (Abu Lughod 2002), and my tools are other Rajasthani women/doctors/agents of development. In this sense, my project is not revolutionary; it seeks to make the government health care system more welcoming for women so that more women can work in villages. Following this logic I become an agent of development in service to the government.

On the other hand, I have chosen this project in response to the problems that women medical students and doctors have themselves articulated. Feminist ethnography tends to be, either explicitly or implicitly, activist in nature, with feminist anthropologists choosing projects that work in some way toward improving the lives of the people they study (Aggarwal 2000, Davis and Craven 2016, Van Hollen 2016). By entering the government sector, doctors have tacitly agreed to participate in the state’s development agenda. Doctors also wish to pursue a career within the existing system that will benefit them. I have made it my job to understand how they define such a career, and what obstacles might be in their way – as I simultaneously question how the deployment of women doctors as agents of the government can serve patriarchal and demographic ends that are not necessarily in the best interests of the marginalized women targeted by government sector health programs.

My analysis of masculine space and feminine risk is my own, deeply informed by Indian feminists and activists, and by the stories of doctors, but not claiming to speak through the unfiltered voices of doctors. In this sense I have taken something from the doctors who opened their lives and careers to my gaze and made it into something different – a scholarly product. I feel some anxiety over this privilege, but the power in this research relationship does not all flow in my direction. Ong (1995) feels that the assumption of an ethnographer’s control over her research relationships may in some cases be misguided, as informants are able to give or
withhold information and steer the relationship in savvy ways. For her, the greater danger lies not in the exploitation of informants, but in “refusing to recognize informants as active cultural producers in their own right, whose voices insist on being heard and can make a difference in the way we think about their lives” (Ong 1995, 354). Part of my job as the chronicler of women doctors’ rural avoidance is to witness and acknowledge the problems women doctors have expressed to me, and to amplify the experiences of women doctors through the publication of my findings in venues that lend a stamp of scholarly legitimacy to these experiences. I also conclude the dissertation with policy recommendations that, I hope, will begin to bridge the gap between the health administration’s goals for rural health care provision and the actual experiences of women doctors. I do not have great optimism in the ability of health planners to easily mitigate the risks that women doctors find attached to rural postings, especially when the problem is far larger than the health sector itself. At the same time, the problem must be tackled, and the health sector is my particular point of entry. If I can link gendered risk, something the government has not shown much interest in, together with women’s reproductive health indicators, a topic in which the government is keenly interested, we might get somewhere.

Outline of the Chapters

In Chapter 2, “Health Care, Women, and Doctors in Rajasthan,” I explore the role of women doctors in the provision of health care in Rajasthan’s government sector. Statistics show a “shortage” of women doctors, particularly in rural areas. The assumption that women doctors are necessary to treat women patients turns women doctors’ rural avoidance into a problem for women’s health. I trace the history of discourse that naturalizes women doctors’ ability to care for women patients from the colonial era to the present. Gender seclusion initially provided an
opportunity for women doctors, first foreigners and then Indians, to practice allopathic medicine in India. This discourse required an assumption of difference: women doctors were not susceptible to the rules that kept potential patients secluded from the public sphere. Today, women doctors are considered similar enough to their women patients in the government sector that they are seen as best equipped to treat these patients. At the same time, women doctors’ gender keeps them from being the mobile agents they are assumed to be in public health policy. This tension between similarity and difference will return in many of the chapters.

In Chapter 3, “On Being a Doctor,” I consider doctors’ entry into the world of biomedicine through the medical college. The structure of medical education at MGMC, with its “exam-crazy” mentality, steers students away from careers as “basic” or primary care doctors and toward super specialties that offer jobs only in urban areas. Although every student takes the exams to get into a post-graduate program where they can specialize, only a small percentage succeed – leaving the rest to become basic doctors whether they like it or not. I explore the moral economy of work in the government and private sectors – what does it mean for young doctors to take a job in the government sector, which usually requires a short-term rural posting? Is medicine a business, where doctors make money to support their families, or is it a service, where doctors help the broader community? How does gender intersect with the moral economy of medicine in Rajasthan?

In Chapter 4, “Reluctant Villagers,” I analyze discourses of the “village” and “city,” seeking to understand the meaning of these categories and how they shape doctors’ career choices. How do medical students imagine what life and work in the village would be like? What kinds of stories do women doctors tell when they have returned from the village? Looking from the position of the city, doctors’ discourse constructed villages as “backward” spaces, empty of
social opportunity and career prestige. A faint counter-narrative that framed rural spaces in positive terms ran alongside the discourse of backwardness, complicating easy distinctions between modern (“good”) cities and backward (“bad”) villages, but never supplanting the dominant narrative. I argue in this chapter that villages are produced as spaces unwelcome to doctors, and to women doctors in particular, through urban narratives of the village and through women doctors’ refusal to occupy rural space.

In Chapter 5, “Risk and Protectionism in the Village of Strangers,” I continue to explore narratives of the village, specifically through discussions of women’s safety and sexual violence. Doctors described the village as a space unsafe for any doctor – but particularly for women, for whom the threat of violence carried an additional risk to sexual purity and family honor. I first consider women’s experience of risk in the city, where women have a difficult time claiming a right to inhabit male-gendered public space. Women mitigate these risks by calling upon their social network to provide travel companions and a symbolic umbrella of paternalistic protection. Women doctors who work in a “village of strangers,” far away from their families, must leave behind the friends and relatives who help them to manage risk in both symbolic and practical ways. In addition, the village empty of amenities is simultaneously full of the “wrong” kind of people – the “unfriendly bodies” of lower class men (Phadke 2013) who are seen to pose a threat to urban middle-class women. These are the men who, in the form of rural-to-urban migrants, become the bogeymen in popular discourse on sexual violence in India’s cities. When women doctors move to a village, they are entering the origin point of this perceived threat.

Finally, in Chapter 6, “Lady Doctors Don’t Have Problems’: Status and Difference in Public Health Discourse,” I link the colonial-era project of difference making that I discuss in Chapter 2 to more recent discourses of development and empowerment, exploring how a
particular definition for “women” is created in public health discourse in the contemporary period. I argue that doctors’ gender is able to fade to the background in the eyes of health administrators because they do not belong in the category “women” as it is defined as the object of public health, development, and empowerment interventions. Women doctors’ class and educational status allows them to escape the developmentalist gaze to which poor women are subjected, but one repercussion of their outsider status is that the label “gender” does not adhere to their problems. As one public health official told me, “lady doctors don’t have problems” – in other words, women doctors’ gender does not cause them problems. This blind spot allows the issue of women doctors’ rural avoidance, and the middle-class feminine risk in which it is tangled, to go unaddressed.
CHAPTER 2
GENDER AND HEALTH CARE IN RAJASTHAN

This chapter explores the current state of health care provision for women in Rajasthan. I begin with a discussion of health care in the government sector. Rajasthan’s government health care system continues to expand but fails to provide comprehensive primary care to the population. I am particularly interested in the problem of “health manpower,” particularly in rural areas, and look at how the state has quantified the shortage of women doctors. The shortage of women doctors does register in public health documents, but only on a superficial level. This discussion sets up the arguments I will make as the dissertation progresses: that the shortage of women doctors is linked to broader problems, particularly that of women’s mobility, while the government health administration fails to see the scope of the problem. In the second half of the chapter I move on to an analysis of gender as it relates to women’s health. I argue that, because of common-sense ideas about gender concordance in health care provision on the part of patients, doctors, and health administrators, women doctors are a necessary part of women’s health care in Rajasthan. I trace the unusual entrance of women doctors onto the medical scene in colonial India and consider women doctors’ continued marked status in the profession. Finally, I begin thinking about the ways in which the category “woman” has been used to justify women’s role as providers of medical care while, simultaneously, differences between women based on class and geographical location are produced through the medical encounter. Here I consider this paradox as it emerged in the colonial era; in Chapter 6 I return to the paradox of similarity and difference between women in the contemporary age of development and empowerment.
Health Care in the Government Sector

No one I met, whether health planner, doctor, or patient, seems entirely satisfied with the provision of health care in Rajasthan. It is not surprising that high-quality, low-cost health care for the population remains elusive; health care for all is something of a rare unicorn in the world, existing only under extraordinary circumstances (we certainly fail on this front in the US). And yet the underlying assumption of my research is that the government should provide health care for all – we still have to hold governments accountable. The idea of universal primary health care blossomed in India in the 1950s, shortly after independence, and was modeled on British and Soviet post-war national health plans (Zachariah et al 2010, 11). At this time the Indian government developed a series of health care institutions in the public sector with the goal of creating world-class, technologically equipped hospitals – a matter of national pride – as well as primary health clinics spread throughout the country. Health planners envisioned a three-tiered institutional structure that included primary care at the local level, small regional hospitals, and large urban tertiary centers each connected to a medical college. The institutional structure laid out in the 1950s still exists today in Rajasthan, now incorporating four levels of clinical care: 1) small sub-centers staffed by one male and one female health worker; 2) larger Primary Health Centers (PHCs) headed by a biomedically trained doctor and sometimes associated with an AYUSH (Ayurveda, Unani, Siddha, Naturopathy, or Homeopathy) practitioner; 3) still larger Community Health Centers (CHCs) with several biomedical doctors including an obstetrician/gynecologist, and 4) urban tertiary hospitals with a wide range of specialists and facilities.
By the 1960s it was clear that the vision for widespread government-sponsored primary care would be prohibitively expensive for India’s economy to manage (Zachariah et al. 2010). The idea of universal primary health care remained in the national consciousness, blossoming again in the 1970s as India joined the global “Alma Ata Declaration of Health for All by the Year 2000” (Peters et al. 2003). In actual practice, the government has struggled to provide basic health care since independence (we are far past the year 2000 and “health for all” has yet to materialize). The infrastructure of public health care centers envisioned during the independence era still exists and continues to expand, often through international funding. But this funding comes at a cost: neoliberal restructuring under the direction of the IMF and World Bank in the 1990s and 2000s brought with it health care “reforms” that favor private sector growth and public-private partnerships. NGOs abound in Rajasthan to pick up where the government leaves off, with the result that it is often difficult to distinguish between the public and private sectors on the ground. Government spokespeople generally frame the expansion of NGOs as a good thing (e.g. Nandan 2010), but critics worry that the private sector cannot be adequately regulated and overseen by an already overburdened state health bureaucracy (Phadke 2016). The reforms also mean that the government is able to spend less and less while still claiming to take action on health care issues. Because individual states and communities are responsible for the day-to-day running of clinics, the quality of health care offered by these clinics varies by state and district depending on local resources and priorities. The health system increasingly must do more with less financial support from national and state budgets. Rajasthan is particularly struggling compared to some Indian states. Rajasthan belongs to what the government calls Empowered Action Group (EAG) states, a euphemistic way of labeling states with high rates of fertility and infant mortality. Rajasthan’s maternal mortality is among the worst of the EAG
states. In other words, Rajasthani women are dying in childbirth at some of the highest rates in a country with an already high average maternal mortality rate. Rajasthan has a high maternal mortality rate despite ninety percent of births taking place in institutions (see Table 3); the push to institutionalize childbirth has been successful in Rajasthan compared to other EAG states, but institutionalized births do not appear to provide a simple solution for maternal mortality. The problem of maternal mortality is beyond the scope of my dissertation, but my research is linked to this issue (however indirectly), and provides a different kind of insight into the issue of women’s health care provision.

Since the 1990s and the opening of India’s economy, the government role in health care has shifted in large part from promoting health for all (in theory) and vertical campaigns (in practice) to protecting the open market. Health care has become a profit-making enterprise for the nation, and the concept of health care as a human right has transformed into “health as a right in terms of economic access” (Qadeer and Chakravarthi 2010). In other words, the government now claims responsibility only for ensuring that everyone can afford access to some kind of health care. This responsibility is increasingly taking the form of state-funded health insurance that allows patients to access private sector care – and further intertwines the public and private health sectors. In 2015 Rajasthan introduced an ambitious health insurance program that claims to cover health costs, including use of the private sector, for sixty-eight percent of the state’s population (Bahri 2018), although the cost savings for patients of state-funded health insurance in India have been disputed (Karan et al. 2017). Zachariah et al. (2010) term the shift in the government’s health care orientation “development medicine.” Rather than providing holistic health care, government policy treats health in the same way it treats economic growth or modernization, “as something to be planned centrally by experts and policy makers in the long
term interests of ‘the nation’” (Zachariah et al. 2010:11). The result is vertical campaigns inspired by whatever diseases or problems – such as maternal mortality – are on the global health agenda, and solutions that map on to neoliberal economic agendas. While the contours of the change are economic, the repercussions are felt beyond government budgets and patients’ wallets. The transformation from ‘medicine for the people’ to ‘medicine as capital’ affects how doctors see their place in Indian health care. The question of what medicine is and what it should be, along with the doctor’s responsibility to herself, the population, and the nation, is a theme that flows throughout my research and one I tackle in greater detail in the next chapter.

Weaknesses in the government sector health care mean that potential patients look elsewhere for help: the private sector, a diverse and largely unregulated set of institutions ranging from prestigious urban corporate hospitals to individual practitioners working out of a small storefront or their own home. Private sector practitioners of all types must stay in one location in order to develop a reputation and a patient base allowing patients to build a relationship with private practitioners that is difficult to achieve in the government sector, where doctors tend to rotate through, particularly in undesirable rural areas. A study of rural health in Rajasthan’s Udaipur district found that fewer than a quarter of patients used government sector clinics, preferring private practitioners instead (Banerjee et al. 2004).

India’s medical landscape is highly pluralistic for reasons beyond the failures of the government health care system. Indigenous systems such as Ayurveda, Unani, and Siddha, “alternative” relatively recent imports such as naturopathy and homeopathy, and various types of religious and folk healing have long been popular and continue to thrive (Das 2015; Flueckiger 2006; Halliburton 2009; Lambert 2012, 1996; Langford 2002). Non-biomedical types of healing available in India also offer a more social and contextual theory of health and illness; these
practitioners are likely to view the patient as more than a mere body to be fixed. Patients may also find more respect in the private sector where, again, practitioners’ success depends on building a loyal clientele. The existence of a flourishing and diverse private sector does not negate the need for a working government sector, especially when so much of the private sector operates without formal training (eighty-two percent of the private practitioners in Banerjee et al.’s (2004) study had no formal training of any kind). As one of my informants asked, how can we make the government sector more like the private sector, meaning how do we create a resource that patients will want to use?

<table>
<thead>
<tr>
<th>State</th>
<th>Maternal Mortality Rate (per 100,000 live births) 2010-12</th>
<th>Institutional Births (percentage of total registered births) 2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerala</td>
<td>66</td>
<td>99.8</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>87</td>
<td>94.4</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>90</td>
<td>99.6</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>110</td>
<td>95.1</td>
</tr>
<tr>
<td>West Bengal</td>
<td>117</td>
<td>72.4</td>
</tr>
<tr>
<td>Gujarat</td>
<td>122</td>
<td>93.7</td>
</tr>
<tr>
<td>Karnataka</td>
<td>144</td>
<td>97.1</td>
</tr>
<tr>
<td>Haryana</td>
<td>146</td>
<td>83.4</td>
</tr>
<tr>
<td>Punjab</td>
<td>155</td>
<td>77.6</td>
</tr>
<tr>
<td><strong>Empowered Action Group (EAG) States</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bihar</td>
<td>219</td>
<td>78.5</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>219</td>
<td>63.7</td>
</tr>
<tr>
<td>Chhattisgarh</td>
<td>230</td>
<td>57.6</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>230</td>
<td>86.1</td>
</tr>
<tr>
<td>Odisha</td>
<td>235</td>
<td>84.8</td>
</tr>
<tr>
<td>Rajasthan</td>
<td><strong>255</strong></td>
<td><strong>90.6</strong></td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>292</td>
<td>61.7</td>
</tr>
<tr>
<td>Assam</td>
<td>328</td>
<td>80.2</td>
</tr>
</tbody>
</table>

Table 3: State-Wise Maternal Mortality Rate and Percentage of Institutionalized Births (Source: GOI 2013).
<table>
<thead>
<tr>
<th>State</th>
<th>Number of PHCs</th>
<th>Without electric supply</th>
<th>Without regular water supply</th>
<th>Without all-weather road</th>
<th>With referral transport</th>
<th>With labor room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerala</td>
<td>829</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>1811</td>
<td>4</td>
<td>0</td>
<td>11</td>
<td>98</td>
<td>91</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>1369</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
<td>90</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>1709</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>West Bengal</td>
<td>909</td>
<td>8</td>
<td>12</td>
<td>9</td>
<td>26</td>
<td>100</td>
</tr>
<tr>
<td>Gujarat</td>
<td>1158</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
<td>97</td>
</tr>
<tr>
<td>Karnataka</td>
<td>2233</td>
<td>7</td>
<td>3</td>
<td>7</td>
<td>24</td>
<td>71</td>
</tr>
<tr>
<td>Haryana</td>
<td>454</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>76</td>
<td>71</td>
</tr>
<tr>
<td>Punjab</td>
<td>427</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>23</td>
<td>64</td>
</tr>
</tbody>
</table>

|               |                |                        |         |                   |                        |          |
| Empowered Action Group (EAG) States |            |                        |         |                   |                        |          |
| Bihar           | 1883           | 0                       | N/A    | N/A               | 20                     | 26       |
| Jharkhand       | 330            | 42                      | 55      | 10                | 17                     | 61       |
| Chhattisgarh    | 783            | 11                      | 21      | 14                | 32                     | 78       |
| Madhya Pradesh  | 1157           | 0                       | 10      | 16                | 56                     | 97       |
| Odisha          | 1305           | 11                      | 22      | 1                 | 14                     | 78       |
| Rajasthan       | 2082           | 10                      | 15      | 24                | 57                     | 73       |
| Uttar Pradesh   | 3497           | 6                       | 8       | 13                | 11                     | 45       |
| Assam           | 1014           | 9                       | 13      | 4                 | 42                     | 71       |

Table 4: State-Wise PHC Infrastructure, 2013-14 (Source: GOI 2014).

Women’s Health and Population Control

Women entering the government health care system are ideally supposed to do so at the most local level. If a woman living in a village becomes pregnant, the female health worker at her local sub-center will refer her to a PHC for prenatal care and, if the center is equipped for it, her delivery. If the doctor at the PHC detects any problems requiring intervention, the woman will be referred to a nearby CHC to see a specialist. If she has a more complicated problem, she will be referred to the urban tertiary hospital. In practice, the flow of patients from primary to secondary to tertiary clinics rarely runs so smoothly. A pregnant woman living in a village within easy travel of Jaipur might go straight to the capital’s designated tertiary care center, SMS Hospital, to give birth, feeling that SMS has the best doctors and the highest prestige. Or a woman might go repeatedly to her local PHC for prenatal care only to find the doctor absent. Capturing all the...
complexities of health-seeking behavior is beyond the scope of my research – but, thankfully, others have focused on the experiences of patients (as well as other types of practitioners) in South Asia. By zeroing in on doctors and their experiences, I hope to add one small bit of clarity to the moving parts of Rajasthan’s health care system.

<table>
<thead>
<tr>
<th>Staff</th>
<th>Population Served (Normal area/difficult area)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Center (SC)</td>
<td></td>
</tr>
<tr>
<td>• auxiliary nurse-midwife (ANM)</td>
<td>5000/3000</td>
</tr>
<tr>
<td>• male health worker</td>
<td></td>
</tr>
<tr>
<td>Primary Health Center (PHC)</td>
<td></td>
</tr>
<tr>
<td>• medical officer</td>
<td>30,000/20,000</td>
</tr>
<tr>
<td>• 14 other staff (including nurses, pharmacist, AYUSH)</td>
<td></td>
</tr>
<tr>
<td>Community Health Center (CHC)</td>
<td></td>
</tr>
<tr>
<td>• surgeon</td>
<td>120,000/80,000</td>
</tr>
<tr>
<td>• physician</td>
<td></td>
</tr>
<tr>
<td>• obstetrician/gynecologist</td>
<td></td>
</tr>
<tr>
<td>• pediatrician</td>
<td></td>
</tr>
<tr>
<td>• 21 other staff (including medical officers, nurses, pharmacist, AYUSH)</td>
<td></td>
</tr>
</tbody>
</table>

Table 5: Types of Rural Clinics (Source: Chokshi et al. 2016).

Following independence, the Indian government – with pressure from US-based organizations such as the Rockefeller Foundation and the Ford Foundation – began to work toward stemming population growth (Rao 2004). This shift was based on a neo-Malthusian argument that overpopulation was a cause of poverty rather than a result. From the 1940s through the 1990s (and beyond, as many would argue), women’s health care became synonymous with family planning. Family planning policies addressed populations rather than individuals, but the results had a dramatic effect on men and women’s reproductive lives. When population policy was enacted on individual bodies, it often took the form of forced sterilizations, the most insidious example being government sterilization camps for men in the 1970s (Dhanraj 1991, Rao 2004). Family planning agendas have since shifted to the bodies of
women. Until 1997, public health workers had to fill a quota of intrauterine contraceptive devices (IUDs) inserted or sterilizations performed on women (Menon 2004). Practitioners at all levels, from obstetricians who carried out sterilizations to frontline health workers who “motivated” sterilization cases, were subject to quotas – and to penalties if they failed to fill them. While health workers were instructed to convince women to voluntarily accept these procedures, it felt more like coercion to many of the women who experienced them (Jeffery et al. 2002, Van Hollen 2003).

Following recent global trends in women’s reproductive health, Indian health policy has abandoned the quota system and adopted a more holistic definition of women’s health that includes issues not directly related to contraception and sterilization. The Indian government’s Reproductive and Child Health Programme (RCH), initiated in 1997, emphasizes institutional deliveries, immunization, treatment of anemia, pre-natal care, early identification of maternal complications, birth spacing, and the detection and treatment of sexually transmitted diseases and reproductive tract infections (Anand 2004, 172). Indian health policy now positions the availability of these health resources as a basic human right. Yet researchers working a few years after the dissolution of family planning targets argue that little had actually changed on the ground: Unnithan-Kumar (2002) found that women escaped state family planning agendas by avoiding government sector health care, and Menon (2004) reported that “reproductive health” camps still operated as sterilization camps and sent away women with other complaints. As recently as 2014, a sterilization camp in Chhattisgarh made headlines after thirteen women died – the surgeon had operated on eighty-three women in three hours. Women who wish to avoid state-sponsored population programs have turned to the private sector, providing yet another reason for the unpopularity of the government sector.
Donner’s (2008) ethnography of motherhood in middle-class, urban Calcutta gives a few hints about potential differences in views of childbirth between middle-class women and the lower-class women who are usually the subject of research on reproduction in India. The young middle-class women in Donner’s study had few children (usually one or two) and used contraception. They all expected to give birth in a private nursing home, preferably through caesarean section. Donner suggests that doctors who work in private nursing homes have the opportunity to develop long-term relationships with their patients over the course of pregnancy, birth, and post-natal care. In one of Donner’s examples, a doctor called her pregnant patient to offer her a scheduled caesarean; this is unthinkable at a public hospital. What is “best” for these patients appears to be choice, comfort, and privacy, a vastly different scenario from forced IUD insertion or sterilization. Of course, women who can access private nursing homes are already acting in accordance with state family planning objectives and thus avoid becoming the targets of unwanted reproductive health interventions.

The family planning regime has eroded patients’ trust in government health care, and it will take more than a change in policy to rebuild good relations. Although the quota system has been abandoned, the discourse of population control continues to guide the thoughts of many doctors who work in women’s health. This discourse sets women’s health at the level of population (good for the nation) rather than individual (good for the patient). The doctor’s job then becomes helping as many people as possible as well as knowing what is best for the population. And, in the minds of many doctors, what is good for the population is also good for the individual patient. Doctors become frustrated with women who do not follow “modern” or biomedically-recommended fertility patterns. In patrilocal north India, doctors are likely to
appreciate the desire to have a boy, but not the impulse to have ten or more children to achieve it.  

Doctors are not unsympathetic to the problems their patients face. For example, one of the most common problems facing poor women is vaginal infections. One doctor explained to me the difficulty of keeping good menstrual hygiene for women who live in urban slums: they use rags during their period, but cannot dry them in the sun to disinfect them, which would require putting them on display for all to see. She did not have a good solution for this problem; it is not easy to eradicate menstrual taboos, nor can poor women afford disposable pads. Because vaginal infections have not been a priority in world health, there is no organized campaign in Rajasthan to deal with them. The doctor can advise drying rags in the sun but cannot fault her patient when she does not comply. Childbearing is another matter. As I show below, the Indian government has invested many resources into curbing maternal mortality in Rajasthan. Doctors are a crucial part of the government health apparatus to bring birthing women into the biomedical fold; therefore, doctors tend to be invested in the success of government childbirth programs and frustrated when they fail to bring women’s behavior in line with biomedical protocol.

*Medicalized Birth*

In much of the world, the gold standard of women’s reproductive health care includes a large cadre of trained professional midwives for routine cases along with emergency obstetric care available if something goes wrong. This model exists in India on paper. Every PHC is responsible for several subcenters, each employing an auxiliary nurse midwife (ANM) to provide family planning services, immunizations, sanitation, infectious disease prevention and care, and
perinatal care to women. The ANM is part of the first line of contact for women and is expected to encourage women to enter the allopathic system for health problems, as well as perinatal care, and to refer upwards in the system if necessary. ANMs are assisted by accredited social health activists (ASHAs), village-level volunteers who receive a small financial payment for every woman they bring into the system. ANMs were originally expected to preside over births (hence the “midwife” part of their designation). Since the 1970s, ANMs have been repositioned as “multi-purpose workers,” with shorter training and no expectation of delivering babies (Mavalankar and Vora 2008). More recently (in the early 2000s) the NHM has begun training some ANMs in the state in midwifery skills, along with equipping some subcenters with delivery rooms (Iyengar et al. 2009). In theory, ANMs should also be equipped to attend normal births, thereby expanding the reach of the allopathic system into every village. However, long-term efforts to train women to become ANMs, or to train traditional birth attendants in allopathic methods, have failed to create a large number of midwives who are skilled birth attendants and who consistently use the evidence-based standards promoted by global health organizations (Jeffery et al. 2002, Pinto 2008, Price 2014). The current system still requires ANMs to travel regularly between several villages, leaving the subcenters empty for much of the time – and defeating the purpose of labor rooms in subcenters. Iyengar et al. (2009) found that the clinical structure of the government sector in Rajasthan expected doctors to preside at births with nurses assisting. In all of India, doctors attended fifty-six percent of births, while health workers with varying degrees of training (including ANMs and nurses) attended only twenty-five percent of births (GOI 2017).

Researchers (myself included) often blame a lot on the government as abstract entity when it comes to health care failures. On the ground, of course, “the government” comprises a
lot of well-meaning and hard-working people who struggle to do what they can given the constraints of global economic and political pressures. I met Nidhi Madam in the Rajasthan government health headquarters, a dusty building in a posh Jaipur neighborhood near European-style cafes and boutiques selling expensive hand-block-printed clothing. Nidhi Madam worked for the National Health Mission (NHM), a branch of the Ministry of Health and Family Welfare. The NHM was founded in 2005 as the National Rural Health Mission, meant to improve health care outside of urban areas in eighteen struggling states, of which Rajasthan is one. Its success prompted the government to add an urban component in 2014, during the time of my fieldwork; when I met her, Nidhi Madam was working to implement the then-one-month-old Urban Health Mission.

The NHM runs several schemes to facilitate pre- and post-natal care for women and babies, and to encourage pregnant women to behave in line with the government’s desires. Nidhi Madam listed for me the twelve yojanas, or schemes, that apply to women’s reproductive health. She spoke of the yojanas with pride and with optimism for their success. The Janani Shishu Suraksha Karyakram (“mother and child protection program”) promises free deliveries for mother and baby, including diagnostics and surgery if necessary. The Janani Suraksha Yojana (“plan for the protection of mothers”) gives women a small financial grant for delivering in a government hospital or one of the 160 private accredited hospitals in the state. The Janani Express Yojana provides a vehicle to take laboring women to the closest hospital. Another scheme gives village-level volunteers named accredited social health activists (ASHAs) a financial incentive for encouraging pregnant women to enter the government system.

It is important to note that the majority of the twelve yojanas detailed by Nidhi Madam address patient behavior, steering potential patients into the fold of the biomedical system and
away from other options for reproductive health.\textsuperscript{19} Government policymakers and doctors alike often focused on patient behavior as a major obstacle to the health of the nation. This may be for practical reasons: changing patient behavior is cheaper and easier than upending the neoliberal world system that funnels resources away from the provision of a wide range of preventive and curative services. Furthermore, in the case of failure, the “backwardness” of the population makes for an easy scapegoat. For health planners, then, convincing pregnant women to enter the allopathic health care system and keeping them there for delivery became the solution to reduce maternal mortality. The schemes are by their very nature a stop-gap measure; they can be renewed, but they are not meant to last forever. The idea is that once the behavior of the population changes, the schemes will no longer be necessary. Temporary schemes follow the same logic as vertical disease eradication campaigns in that they address one issue rather than providing holistic wellness throughout a woman’s life. The idea is certainly good – get women into a system that can provide life-saving interventions. Yet what happens when a woman agrees to enter the system but finds it cannot deliver on its promises?

Discontinuity of care is a major problem for those seeking health care in India. George (2007) observed constraints on the delivery of maternity care in a rural district of Karnataka, South India. She found that “existing monitoring routines are procedurally biased against supporting continuity of care” (George 2007:97). Health workers were held accountable for the number of treatments they gave, showing proof of work done, but not for the actual outcomes of their treatments. In other words, there was no incentive to do any kind of follow-up work when a woman was diagnosed with a potentially dangerous condition, such as pre-natal anemia. Ruddock (2016) found a similar discontinuity of care in her study at AIIMS, arguably the nation’s most prestigious government hospital, located in the Northern capital of Delhi. AIIMS is
meant to be a tertiary hospital for cases requiring specialist care, but in practice people flock to the hospital with all levels of illness. No one oversees their care, so patients tend to shop between doctors, carrying their medical records with them in tattered bags or plastic folders. Patients bounce between specialists and generalists without flowing smoothly in the primary-secondary-tertiary direction envisioned by the system. Once a diagnosis is made, no one follows up to make sure that a patient understands, or follows through on, the treatment regimen. Ruddock illustrates the kind of “episodic care” that happens at AIIMS, “in which the absence of a coherent medical record and a primary physician conspire to splinter a patient into a constellation of symptoms responded to differently by different specialists…. ‘[T]reatment’ seems to be defined more as the act of presentation to a doctor than the receipt of coherent care” (Ruddock 2016:229).

The past decade has seen a dramatic rise in the number of institutional births in Rajasthan. In 2005-2006, only thirty-two percent of births took place in government sanctioned institutions. By 2011-2012, just over ninety percent of the state’s births took place in institutions. The NHM’s work in the intervening period, including the implementation of yojanas and the designation of ASHAs in each village to encourage women to engage with the government system, has played a large role in this change. But, without doctors in rural clinics who are positioned to deal with an increase in deliveries, already-overburdened urban district hospitals must somehow accept a greater number of patients. If a frontline health worker detects something amiss and refers a woman onwards in the government system, the patient is likely to come up against the lack of women doctors (both medical officers and specialists) who can attend to her problem.
**Doctor Shortages**

Government health statistics tracking “health manpower,” as practitioners are labeled in India, show the distribution of doctors in Rajasthan. Doctors tend to follow the same pattern as hospitals: they are disproportionately clustered in cities and are often missing in rural areas. The state government tries to apportion clinics and health care providers based on population numbers; for instance, there should be a PHC with at least one doctor for every 30,000 people. This ideal breaks down in practice as the state cannot find enough doctors to fill all rural positions. Table 7 outlines the shortage of doctors in rural clinics in Rajasthan. The most common type of doctor is a medical officer, a primary care doctor who has graduated with an MBBS (bachelor of medicine/bachelor of surgery) degree and is generally tasked with leading a PHC. The number of medical officers in place in Rajasthan appears to be sufficient based on the state’s population estimates. Looking at the next column, the number of “sanctioned” positions – meaning that salary money has been earmarked and the position has been officially created – the situation looks even better, for there are more sanctioned positions for medical officers than there are PHCs. The problem is that some PHCs have more than one doctor, while others have none. Rajasthan had 323 PHCs functioning without a doctor in 2014. When we turn to the specialists who are designated to work in CHCs, the shortfall becomes glaring. Most important for my research is the obstetrician/gynecologist. According to health policy, there should be an obstetrician/gynecologist at every CHC. In Rajasthan, only nineteen percent of CHCs have an obstetrician/gynecologist in place. The majority of women in the state, therefore, do not have access to a reproductive health specialist in the government system without traveling to a large city.
<table>
<thead>
<tr>
<th>Required</th>
<th>Sanctioned</th>
<th>In Place</th>
<th>Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officer</td>
<td>2082</td>
<td>2562</td>
<td>2111</td>
</tr>
<tr>
<td>Surgeon</td>
<td>567</td>
<td>523</td>
<td>190</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>567</td>
<td>250</td>
<td>105</td>
</tr>
<tr>
<td>Doctor (MD)</td>
<td>567</td>
<td>524</td>
<td>254</td>
</tr>
<tr>
<td>Pediatrician</td>
<td>567</td>
<td>214</td>
<td>102</td>
</tr>
</tbody>
</table>

**Table 7: Doctors Working in PHCs and CHCs, Rajasthan, 2014 (Source: GOI 2014).**

Compounding the problem of doctor shortages is absenteeism. Doctors and other health personnel are not always where they are supposed to be during the clinic’s official working hours. A survey conducted in 2004 in Rajasthan’s Udaipur district found that, on average, thirty-six percent of all health care personnel (including doctors and other staff) were absent in government PHCs and CHCs (Banerjee et al. 2004). A 2011 survey found that forty-seven percent of doctors in Rajasthan (along with thirty-four percent of nurses) were absent during unannounced visits by the survey staff (Muralidharan 2011). Absenteeism spanned nearly every aspect of my research as well. Doctors were missing from PHCs, medical students were missing from their rural rotations, and professors were missing from class. I often became frustrated after having traveled a long distance to find someone, only to be told to come back the next day. I kept trying – it was my job, after all, to look for doctors. What of a sick person in need of help, or a woman in labor? Or anyone without the time and money to make multiple trips to a clinic or hospital?

Thinking about women’s health, I am most concerned with the number of women doctors available in rural areas. Women doctors are a necessity in Rajasthan where many women will only seek health care if it comes at the hands of a woman provider. In a study of pregnancy-related referrals in rural Rajasthan, Gupta and Gupta (2000) report that half of respondents did
not follow up on a referral because there was no lady doctor available.\textsuperscript{21} The desire for doctor-patient gender concordance, which I address in greater detail further on in the chapter, was a matter of common sense in Rajasthan. A PHC may have a wonderful and committed doctor, but if that doctor is a man, women are unlikely to trust him with health issues seen as intimate, including reproductive health matters.\textsuperscript{22} In 2013-14, only ten percent of PHCs employed a woman doctor (GOI 2014). There are many more women working in positions of first contact with the allopathic system: the ASHA “motivators” and ANMs, both of whom are responsible for helping women through the government system. But if one of these workers finds something amiss and refers a patient onward in the system, the chance of easily finding more women providers is low in the male-dominant PHC and CHC circuit.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure3.png}
\caption{Percentage of PHCs with Lady Doctor, 2013-14. (Source: GOI 2014).}
\end{figure}
Public Health Approach to Rural Avoidance

India’s public health apparatus is keenly aware that rural healthcare services are less than ideal and that doctor shortages contribute to the problem. Several survey-based studies have explored low doctor retention (Jayaram 1995, Rao et al. 2010, Sheikh et al. 2012, Sundararaman and Gupta 2011). While these studies bring up many important points, I find two aspects of the problem to be missing in this literature: 1) a deeper understanding of what rural work means for doctors and their families; and 2) an acknowledgment of gender differences in doctors’ ability to serve in rural areas. I briefly review recent literature on rural avoidance to set the stage for my own intervention.

Jayaram’s (1995) research found that flaws in India’s system of medical education steer graduates away from rural work. Jayaram argues that the curriculum of medical education does not contain enough emphasis on public health. Though departments of community health exist in every medical school, they are low in terms of prestige. And, as I will show in Chapter Two, mandated experiences in urban and rural primary health clinics, especially during the internship year, do not have much impact on students’ knowledge of basic primary care or their desire to serve outside the city. Second, Jayaram found that medical education in India pushes students towards specialization, even while most students will not be able to achieve admittance to a specialist residency. Becoming “merely” a medical officer with an MBBS degree is no longer the end goal. Third, students felt that they had invested so much into their medical education – both in terms of financial cost and time – that they would need to work in an urban setting to recoup their investment. For all of these reasons, MBBS graduates are likely to see working in a village as a means to a different end – ideally, a seat in a specialist residency. My own findings twenty
years later show that these systemic problems in medical education still work to keep doctors out of villages (I explore this issue in greater depth in the next chapter).

Various Indian states, as well as the national government, have toyed with making one- or two-year rural postings mandatory for all MBBS graduates with minimal success. Students protest any new ruling, and, should their protests fail, they can get out of their rural posting by paying a fine. The fine becomes just another cost of medical education for all but those dedicated to serving rural populations, or for those without the financial resources to pay. Following the lead of several other Indian states, the health administration of Rajasthan tried to mandate a two-year rural posting for all medical graduates; after students protested, the government backed down. They have more recently tried the carrot approach, reserving a proportion of seats in specialist post-graduate programs for doctors who have worked in a village. The desire to specialize is a powerful one for recent medical graduates, and students are sometimes willing to put up with a short rural posting to get a benefit for post-graduate admissions. So far this seems to be the best incentive to bring young doctors to the periphery – although luring them back again after post-graduate training is another matter entirely, as evidenced by the glaring shortage of specialists.

In a study exploring attitudes to rural service in Andhra Pradesh (South India) and Uttarakhand (North India), Rao et al. (2010) found a wide range of reasons for doctors to avoid rural work. The list of material goods, people, and services that doctors felt were lacking in villages is a long one, and includes infrastructure, drugs, water, electricity, respect, security, support staff, education for one’s children, and transportation; I explore the “emptiness” of village life for doctors in Chapter Four. Doctors in Rao et al.’s (2010) study also cited local political interference in their work as a drawback to practicing outside the city. Local political
leaders can harass a doctor, tarnish their reputation in the community, threaten them with transfer, demand bribes, request that they prioritize some patients over others, and re-route development funds away from a clinic; alternatively, politicians can ease a doctor’s entry into the community and support their work (George 2009, Rao et al. 2010).

Solving the problems that keep doctors away from village work is not simple. Rao et al. (2010) differentiate between those problems with rural work that can be relatively easily addressed through government policy, including clinic infrastructure, workload, and opportunities for further training, and those problems that are beyond the purview of government health policy, such as safety for women and educational opportunities for doctors’ children. Thus far the only widely implemented incentives to lure doctors into rural areas have been reservations for post-graduate training (the importance of which I discuss in the next chapter) and financial bonuses for rural work. Sundararaman and Gupta (2011) look at incentives adopted by various states across India in order to increase rural retention (see Table 6). Financial incentives exist throughout the country – Rajasthan offers an extra Rs. 7000 per month for doctors working in “hard” (mountainous or desert) areas and Rs. 4000 per month for doctors working in rural areas – but Sundararaman and Gupta are not optimistic about the efficacy of small extra payments to counteract the long list of problems doctors encounter.
State Range of Monthly Incentives for Rural or “Difficult” Areas

<table>
<thead>
<tr>
<th>State</th>
<th>Andhra Pradesh</th>
<th>Bihar</th>
<th>Haryana</th>
<th>Jharkhand</th>
<th>Kerala</th>
<th>Madhya Pradesh</th>
<th>Maharashtra</th>
<th>Odisha</th>
<th>Punjab</th>
<th>Rajasthan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rs. 1000 ($22) for male medical officer</td>
<td>Rs. 3000 ($65)</td>
<td>Rs. 25,000 ($543) for specialist in “difficult” area</td>
<td>Rs. 10,000 ($217) for specialist</td>
<td>Rs. 5000 ($109) in “difficult” area</td>
<td>Rs. 10,000 ($217) for specialist</td>
<td>Rs. 1500 ($32) in “extremist” area</td>
<td>Rs. 8000 ($174) in “remote” area</td>
<td>Rs. 5000 ($109) – Rs. 20,000 ($435)</td>
<td>Rs. 7000 ($152) for “hard” area</td>
</tr>
<tr>
<td></td>
<td>Rs. 1500 ($32) for female medical officer</td>
<td></td>
<td>Rs. 10,000 ($217) for medical officer in “difficult” area</td>
<td>Rs. 5000 ($109) for medical officer</td>
<td>Rs. 3000 ($65) in “rural” area</td>
<td>Rs. 3000 ($109) for specialist</td>
<td>Rs. 1000 ($22) in “tribal” area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rs. 7000 ($152) for specialist</td>
<td></td>
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Not all doctors working in rural areas leave their postings for the city; nor do they unanimously wish to leave. Sheikh et al. (2012) investigated the reasons why doctors stay in remote areas of Chhattisgarh state in central-eastern India. Doctors cited their geographic or ethnic ties to the region and its communities, the ability to make a difference in underserved areas, and financial incentives to staying on in rural government service rather than risking private practice. Not all of the respondents were happy in their rural position – several of them had been requesting a transfer for years, but the government had thus far been unable to find a replacement for them and therefore did not allow them to transfer elsewhere.

The reasons given above for rural refusal resonated throughout my research. Yet these reasons do not tell the story of every doctor; they largely ignore the experiences of women. A few articles mention gender-specific reasons for avoiding the village in passing. For example, Gupta and Gupta (2000) report that “lady doctors hesitate to accept rural postings because of
reasons like safety, education of children and non-availability of basic amenities” (Gupta and Gupta 2000:5). The women in Sheikh et al.’s (2012) study – four individuals, representing eleven percent of the sample – were able to stay in their postings because their husbands, also doctors, were posted in the same area. Mohan et al. (2003) describe the reluctance of Auxiliary Nurse-Midwives (ANMs) to live in their area of work. Like government sector doctors, ANMs are expected to live in or near to their clinical space. The authors reported that the very goal of the government – to make medical care readily available by staffing sub-centers with resident ANMs – also made ANMs susceptible to sexual harassment and violence (Mohan et al. 2003:9). The large number of ANMs is therefore curious: more than the state-recommended number of ANMs has been hired (Iyengar et al. 2009). Of course, whether or not an ANM is actually available in her designated area is another question; Mohan et al. (2003)’s study suggests that this is not always the case.

These studies hint at women doctors’ reasons for avoiding rural areas but do not tackle the issue head on. My focus on the gendered implications of village work expands our understanding of rural avoidance in ways that have thus far gone unexamined. Neither men nor women are eager to take a rural posting and the clustering of doctors in cities reflects this. Both men and women are likely to request transfers in order to locate themselves in more populous, less “backward” areas. Yet, as I show in the chapters that follow, women are particularly unlikely to thrive in village postings. Women doctors’ stories show the difficulties of solving the problem of rural avoidance with easy public health policy initiatives, and perhaps give us a clue as to why public health planners have not considered gender when approaching this issue.
History of Women Health Care Providers

Unlike Europe and North America, where the biomedical profession remained in the hands of men until recently, women doctors have dominated the field of allopathic women’s health in India since its inception. Allopathic care for Indian women began when missionaries, and later formally trained doctors, came from abroad during the colonial period. Gender proved to be the motivating factor for this migration from the colonial metropole: Indian women were secluded from men, therefore women’s health care must be a women-only enterprise. The fields of obstetrics and gynecology remain dominated by women in North India today, and the same self-evident truth remains that women’s health should be women’s business. But as the seclusion of women confronted the male-dominated colonial medical apparatus, it was clear that a different kind of woman was needed, who was not subject to seclusion and who could therefore mediate between women of the zenana and male medical officers. A predicament ensues wherein women are useful to the medical system precisely because they are women, but must also transcend the restrictions placed upon their gender in the male sphere of allopathic medicine. Women doctors are caught between their similarity to their patients – as women – and their difference from their patients, in their supposed ability to transcend gendered norms to move through male-gendered space as agents of the state medical system. Their failure to do so captures much of my dissertation’s focus, as women doctors cannot accept clinical postings that are deemed too risky to their bodies and reputations. I begin, however, by considering the first introduction of allopathic medicine into India during the colonial period, and the difference-making project that it required.

As part of the civilizing mission of the British Raj, colonial discourse framed Indian women as vulnerable to sati, child marriage, female infanticide, gender-based seclusion, and the
dai, or traditional midwife. The introduction of allopathic medical care fit neatly into this rhetoric of liberation from uncivilized practices. Colonial discourse charged Indian men with barbarism toward “their” women, secluding them from the outside world of men – which included male doctors (Forbes 1994, Lal 2006). Lady doctors from abroad were therefore needed to “save the bodies of Indian women” (Balfour and Young 1929:x). The seed for this idea was not planted by colonial officials or Indian reformers, but by British women who had fought to obtain medical training in their own country. The few who succeeded found themselves shut out from medical practice by the men who controlled licensing and entry into the field. Many of these women turned to India as a site of practice. British and Indian doctors are thus intertwined through the history of imperial medicine, with the colonial periphery impacting the metropole and vice versa (Burton 1996). Gender was at the forefront of women doctors’ reasoning: even though British and Indian women came from different cultures, spoke different languages, and wielded very different kinds of power, it was assumed that both had an underlying femaleness that could bring them together for healing. This argument had not worked in Britain, but when applied to India whose women supposedly needed saving, it grew roots.

I want to pause my discussion of allopathy briefly to explore the other options that have been available in pluralistic Rajasthan. The colonial discourse of Indian women’s suffering assumed that women did not have access to adequate health care prior to the arrival of women doctors from abroad. But these doctors did not reach India to find a void of women’s health care; on the contrary, they had to compete with the traditions of midwifery and healing that already existed on the subcontinent. Women would have been treated by Ayurvedic and Unani practitioners, although these male-dominated traditions mostly stayed away from childbirth itself (Van Hollen 2003). Lambert (1995) notes that, prior to the introduction of allopathy into
Rajasthan in the early nineteenth century, these practitioners were under royal patronage and would have been available only to elites. Nowadays the opposite is true: Ayurveda and Unani tend to be less expensive alternatives to allopathy. The state marginally supports Ayurveda and Unani by sponsoring a few positions for practitioners in the public health network, but neither of these healing traditions appears in official reproductive health programs.

Birth work was historically reserved for midwives who did not have access to textually based traditions such as Ayurveda. It is difficult for us to judge the quality of midwives’ knowledge and skills in the nineteenth and early twentieth centuries based on colonial accounts of midwives. Doctors were not complimentary to dais, often openly disparaging their practices (Hodges 2006:9-10). Educated middle-class Indian women who embraced British understandings of hygiene and medicine similarly sought to marginalize midwives’ traditional knowledge and brand them as dirty and dangerous (Forbes 2005:79-80). The colonial medical administration made sporadic efforts to train dais beginning in the mid nineteenth century. By all accounts these trainings were successful neither at improving women’s birth outcomes nor at increasing allopathic control over childbirth (Jeffery 1988:91-2; Hodges 2006:8-10). Balfour and Young (1929) recount the story of a midwife who had undergone training in the Punjab and returned to the hospital for an official inspection. The inspector scolded her for missing a necessary item in her birth kit. “The woman was anxious to show she was not to blame and hastened to explain that the ‘Babu’ (Assistant Surgeon) had taken all the appliances from her after last inspection and locked them away in his cupboard, and had only brought them out that morning” (Balfour and Young 1929:165). Unsurprisingly, it was not possible to transplant the allopathic practices of the colonial metropole to the colonies without their creative transformation.
So what was childbirth actually like in India when lady doctors made their entrance on the scene? It is difficult to gain access to the experiences of birthing women and their attendants through the historical record, tinged as it is with colonial priorities. Jeffery et al. (2002) discourage us from an outright dismissal of colonial interpretations of the dai, no matter how patronizing and orientalist they may be, in favor of a desire to promote women-centric birth traditions. In their research in Uttar Pradesh in the early 1980s, birth work was considered dirty and shameful and performed reluctantly by women who had few other options. Research by Van Hollen (2003) in Tamil Nadu and Pinto (2008), also in Uttar Pradesh, show that birth work outside the hospital remains stigmatized and is often performed by women from low caste groups.27

**Gender Seclusion and Women’s Careers**

Beginning in 1885, the National Association for Supplying Female Medical Aid to the Women of India, popularly known as the Dufferin Fund, opened women-only zenana hospitals and provided scholarships for British and Indian women to study medicine in Indian colleges (Lal 1994). Zenana hospitals differed from the small network of “lying-in” hospitals run by the colonial administration in that they were meant to provide complete gender seclusion to their patients – run entirely by women for women. The Dufferin Fund simplified a diverse range of gender relationships across the subcontinent into one understanding of purdah, or seclusion, and used it to further the cause of a small group of British women (Lal 1994). Zenana hospitals also claimed a very different mission from that of the government health care sector today. Hospitals managed by the Dufferin Fund were meant to attract Indian elite patients, thereby shutting out the majority of the population (Forbes 1994, Hodges 2006). In practice, lower-caste and lower-
class women made up the majority of zenana hospital patients despite the efforts of Dufferin Fund administrators and many of the doctors. The presence of these women made elite patients even more wary of treatment in the hospital, and women doctors would often make house calls for their patients who could afford to remain in purdah (Forbes and Raychaudhuri 2000).

Gender seclusion in the zenana hospitals was under constant threat by the presence of British male doctors who were tasked with overseeing the women doctors. Zenana hospital doctors sought to gain more autonomy with the creation of the Women’s Medical Service of India (WMS) in 1913. Women doctors now had control of their hospitals without answering to a male civil surgeon. The WMS was disappointing to the British women who lobbied for it in other ways, however, as it continued to fund zenana hospitals via philanthropic organizations rather than through official colonial channels (Sehrawat 2013). The reliance on philanthropy continued into the twentieth century, with Lady Curzon, Lady Chelmsford, and Lady Reading all establishing their own funds for women’s health – and reinforcing the idea that women’s health care in India, in both provision and funding, was women’s work (Jeffery 1988). Philanthropy still plays a role in women’s health care in the form of NGOs that fill gaps in government health care.

The newly discovered need for women doctors did not mean that it was easy for Indian women to move into this professional position. There were very few women who had achieved the educational credentials necessary to enter medical college in the first place (Forbes 2004). Dr. Anandabai Joshee, the first Indian woman to attend medical college in the United States, writes about her struggles as a Hindu woman just getting to and from school while she lived in India:

Passers-by, whenever they saw me going, gathered round me. Some of them made fun, and were convulsed with laughter. Others, sitting respectably in their
verandahs, made ridiculous remarks, and did not feel ashamed to through pebbles at me…. If I go to take a walk on the strand, Englishmen are not so bold as to look at me. Even the soldiers are never troublesome; but the Babus lay bare their levity by making fun of everything. “Who are you?” “What caste do you belong to?” “Whence do you come?” “Where do you go?” are, in my opinion, questions that should not be asked by strangers (Dall 1888:86).

Dr. Joshee went to study medicine abroad in large part because of her constant battle with negative public opinion in India. Dr. Joshee was not alone in her struggles. Dr. Kadambini Basu, who graduated from medical college in 1883, came under attack by the orthodox magazine Bangabasi, which “indirectly called her a whore” (Forbes 1996:162). Arnold (1993) writes that early medical graduates “were an eclectic mixture of castes and communities, including Indian Christians, Anglo-Indians, Jews, and Parsis” (p. 267). These communities were less averse to women working as professionals outside the home.

Indian women who managed to achieve a medical degree faced further barriers to their careers. Indian women wishing to study medicine in their own language could only reach “hospital assistant” status, which was well below the rank attained by British women. The WMS kept Indian doctors at a lower tier on the professional hierarchy with a lower salary and less professional autonomy than British doctors received. A gendered and racialized pay scale was in effect: British men working for the Indian medical service received two-thirds more than their female counterparts, and Indian women doctors received ten times less than the already poorly-paid British women (Forbes 1994:525). In 1890, five years after the Dufferin fund’s inception, all ‘fully qualified’ lady doctors (meaning ranked above ‘hospital assistant’ status) were British (Harrison 1994:95). Even those Indian women who managed to achieve full medical degrees remained effectively barred from heading the Dufferin hospitals (Forbes 1994). The Indian run Bengalee newspaper denounced the Dufferin fund, claiming that it aimed “deliberately to exclude our countrywomen from occupying posts of high responsibility,” perpetuating “those
unjust race-distinctions which act as a great hindrance to the advancement of the Indian people” (Harrison 1994:94).

Forbes (1994) follows the career of Dr. Haimavati Sen, a Bengali woman who completed her medical training in 1894. While Dr. Sen received a Dufferin scholarship, she was only able to obtain the lower-ranked vernacular medical degree. Her story is remarkable in that she was eventually assigned a leadership position at a Dufferin hospital. Unfortunately Dr. Sen’s hospital lost its Dufferin funding when she tweaked the purdah requirements to fit the desires of her patients, rather than the desires of the Dufferin Fund. The lived experience of gender relations in Dr. Sen’s Bengal differed from the rigid structure imagined by British administrators. Dr. Sen’s memoir highlights the flexibility of the purdah system that allowed her to negotiate acceptable arrangements for herself and her patients, something British women doctors, lacking knowledge of the local language and practices, managed with less success (Forbes and Raychaudhuri 2000).

Indian women who studied medicine saw a real need for their services. Dr. Joshee echoed the colonial discourse of saving the women of India, but felt that British women were poorly equipped for the job:

There are some female doctors in India from Europe and America, who being foreigners and different in manners, customs and language, have not been of such use to our women as they might. As it is very natural that Hindu ladies who love their country and people should not feel at home with the natives of other countries, we Indian women absolutely derive no benefit from these foreign ladies (Dall 1888:84).

British doctors Margaret I. Balfour and Ruth Young (1929), writing about women doctors in India, do not acknowledge such differences:

It was suggested we should devote a special chapter to Indian medical women. We feel, however, that this is unnecessary, for what is said in these pages, with few exceptions, applies equally to British, Indian and American medical women. All took part in the same movement as pioneers; all met and overcame the same difficulties. The problems we have discussed affect all, and our interests are identical (Balfour and Young 1929:xiii).
Again we see the female seclusion paradox at work. Balfour and Young speak of Indian women doctors as if they are in the same category as British women doctors – but they must be different from the Indian women living in the zenana if they are able to work professionally outside the home. The very idea of an Indian woman doctor threatened the gendered medical ideology of the British. If elite Indian women were subject to the rules of purdah, necessitating women-only hospitals, how could elite Indian women become doctors, a job which required interacting with male doctors and administrators?

“Lady Doctors” in Contemporary India

Despite the early entry of women doctors into the field, women have historically made up only a small percentage of the medical profession. In the mid-twentieth century, women represented between six and seven percent of doctors (Abidi 1988). Based on the 2001 census, women represent seventeen percent of all allopathic doctors in the country. Women’s participation in Indian medicine is unlikely to stay so low for long. In a dramatic shift, women just barely outnumbered men in medical college enrollment in 2013 – while men outnumbered women in every other field, sometimes dramatically so. Yet these enrollment numbers are not represented in Rajasthan. Enrollment statistics for the general field of medicine in Rajasthan (this includes nursing and AYUSH, both women-dominated fields) show women at only twenty-nine percent of the total. In the two Jaipur medical colleges I visited, women represented a quarter of the students.

Much has changed for women doctors since the colonial period. Medicine as a career for women is now entirely unremarkable, which is perhaps why there has not been much scholarly interest in contemporary women doctors. Most research focuses on the career path of women
doctors: specialization, teaching and research duties, and doctors’ commitment to the field (Bhadra 2011, Bhargava 1985, Sagar 2009, Sood and Chadda 2010). Other researchers have looked at the social background of women doctors (Abidi 1988) and the multiple roles that a woman doctor inhabits (Bhargava 1983, Sood and Chadda 2010). These studies answer questions with quantitatively analyzed data: how many women doctors are there? How many go beyond the MBBS degree, and into which specialty? How many come from various caste and religious groups? The answers are not very surprising: there are far fewer women doctors than men, but their numbers are growing. Women doctors continue to dominate obstetrics and gynecology and otherwise tend to choose fields considered “soft” specialties in India: for example, endocrinology, hematology, ophthalmology, psychiatry, and pediatrics. Women doctors tend to come from elite socio-economic backgrounds and urban areas, although educational reservations in place since 2006 are beginning to complicate this picture somewhat. Women doctors take their family responsibilities into consideration when thinking about their career. These articles spend a lot of time on specialty choice, specifically which specialties are considered feminine and which masculine. Medical students complained to me about the state of affairs that kept women doctors in obstetrics and gynecology departments even when they longed to do something else. But most women doctors do not specialize at all – they complete an MBBS degree and work as medical officers or as generalists in the private sector. When scholarly debates focus on specialization, we miss out on the experiences of the majority of women doctors.

Women doctors at all levels occupy a marked gender category. From the colonial era onwards, women have been “lady doctors,” responsible for women’s health, while men are simply “doctors,” managing everything else. Even when men and women have the same training, as they do when they graduate with an MBBS, women doctors are expected to be available
mainly for women patients. Women are often still referred to as a “lady doctor” rather than “doctor.” Scrolling through the lists of faculty at Rajasthan’s top public hospitals, one sees mostly men’s names in most departments – and then nearly all women in obstetrics and gynecology. When I began preliminary research in 2010, it was common to see a woman doctor listed as “Dr. (Mrs.),” followed by her name. I never saw a male doctor’s gender specified. (Five years later a search of hospital websites turned up no gender markers at all, showing a potentially significant shift.)

Dr. Meenakshi had recently become the in-charge doctor of Devipura CHC after her husband, the previous in-charge, was transferred away. As one of the lady doctors at the CHC, she was used to spending her days treating women patients. Whereas I heard younger medical students complain about being pigeon-holed into the “lady doctor” category, Dr. Meenakshi preferred to treat women, who posed no risk to her feminine respectability (I explore the contours of this risk in Chapter 5). She also felt that, because of her life circumstances as a woman, she was ill-prepared to do her current administrative job well.

Women don’t get a lot of exposure in our early life. I can do well with treatment. But administration, and dealing with the police – in these I’m not so competent. Males are more dominant, they can do a better job with this. They will speak sharply.

Dr. Meenakshi does not point to any inherent difference between men’s and women’s ability to do these things. Rather, her critique is a social one. It is because of gendered norms that Dr. Meenakshi is poorly prepared to be a hospital administrator, where many of the tasks required of her take place in male domains. For example, men handled much of the formal financial administration of doctors’ households in Rajasthan. Over the course of a year living in my Jaipur apartment, I had to deposit cash into my absentee landlord’s bank account every month for the rent. Only once did I see another woman in line at the bank. Many of the tellers were women, but
the people fighting for space in the line were men. A group of PG students in preventive and social medicine confirmed this gendered divide. I had posed a hypothetical scenario where one of the PG students was working in a village and his wife was working in Jaipur. He said it would be difficult for him because “there will be no one to prepare my food.”

JK: Is it difficult for your wife also, if you are posted elsewhere?
Dr.: Yes, because there are things that ladies can’t do without men.
JK: What kinds of things?
Dr.: Ummm [it took him some time to think of an example] … banking.

When I asked why women couldn’t do banking, he found it difficult to come up with a reason; nor could anyone else in the group participating in our conversation. I had hit upon something that was so obvious it made my question ridiculous. Another doctor I met did not know what her salary was because her husband took care of the family finances. Middle class women had their own informal financial networks made up of other women with whom they created savings and lending schemes, but formal financial transactions were the province of men.

These differences appear even before doctors enter the workforce. An MBBS student at MGMC complained to me that conditions in the girls’ hostel were much worse than conditions in the boys’ hostel precisely because girls were not able to do what was required to improve them.

[The boys] have complained. They didn’t like the food, so they ended up beating up the cook. The cook ended up in the hospital with injuries! But after that things in the mess were better. The problem for us is that girls can’t do this kind of fighting. The food is bad, but we can’t fight with the cook. So nothing improves for us.

Girls, then, were unable to call upon the kind of violence necessary for the administration to take note of their complaints.

Subrahmanyan (2009), writing about women research scientists in Madras, brings up issues that are also relevant to women in the medical field. One major problem women face is their inability to make and maintain informal relationships with male colleagues, leaving them
out of the scientific community. Subrahmanyan explains how scientists must lobby for research funding, which requires initiating informal interactions that often take place after hours with men at funding agencies. Women are simply not able to do this in much of India, including Rajasthan. Subrahmanyan quotes a woman who is the head of her department who found it hard to “invite visitors and schedule meetings, lectures, workshops, or conferences because as a woman she cannot entertain them in the evenings, take them out for dinner or shopping, etc. (Subrahmanyan 2009:190). If a woman did do these things, it would be seen as highly inappropriate and could negatively affect her career.

Women doctors had different reactions to crossing into male domains. Some thrived on administrative work, such as Dr. Anandi, the in-charge at Vijaynagar CHC, who took great pride in running her clinic well. I also met many women doctors who were had no problem with “speaking sharply.” As diverse as Rajasthan’s gender practices are, we can expect that doctors will come to their practice with different levels of comfort in interacting with, and overseeing, men. But it is important to note that many of the administrative tasks required doctors to enter male gendered spaces, and this could cause considerable stress for women. Dr. Meenakshi did not refuse to do her administrative duties because they were not appropriate for women. But the stress of being marked, of being in places where she did not belong, made her dislike her job. The next time I visited Dr. Meenakshi, her husband had been transferred back to the CHC and had resumed his administrative duties. Dr. Meenakshi was very happy to be back treating her (female) patients, a task well within her comfort zone.
**Gender Concordance**

It is generally agreed upon in public health circles that more women doctors are needed in India in order to be available for women patients. The impulse to match women doctors with women patients (termed “gender concordance” in biomedicine) creates a demand for women doctors. Dr. Anandi, the in-charge of Vijaynagar CHC, told me that “patients are quite happy with a female doctor. It is beneficial, it is good for a female doctor that patients will come to you only. They don’t want to go to a male gynecologist – they want a female gynecologist.” Dr. Anandi told me this in the context of a question about what subject she would like to specialize in, given the opportunity (she had just taken the post-graduate entrance exam). She replied, laughing at my silly question of “choice” when all is determined by an exam: “what subject do I want? Maybe gynae, pediatrics, or medicine. All are good for female.” When I asked what it meant for a specialty to be good for females, she said: “it means patients are quite happy with a female doctor.” The presence of a woman in one of these specialties does not require patients to question their assumptions about gender and doctors. I explore the issue of specialty choice more in the next chapter.

There can also be too much of a good thing, especially when lady doctors are in short supply. According to Dr. Bindu, an obstetrician working in a Jyotipura CHC in Dausa district: “Ladies like coming to a lady doctor. I am the only one here, so I face many problems…. There is no one else to look after them [woman patients]; there aren’t other caring doctors. So they come to my house. I told them to go to another doctor but they wouldn’t – they only want to see me.” Every doctor I asked (save two exceptions, whom I discuss below) agreed that most woman patients preferred to consult a woman doctor. This fact was taken for granted, which made it hard for doctors to explain to me exactly why women had this preference. The most common answer
had to do with “comfort” – women are simply more comfortable in the presence of other women. This is not surprising given that social division by gender is a way of life throughout much of north India.

I met two doctors who felt the gendered division of medicine was arbitrary. Dr. Vijay was a male obstetrics student at MGMC, and his father, Dr. Deepak, ran a thriving private obstetrics practice in a middle-class neighborhood that abuts a poorer neighborhood occupied primarily by migrants. I happened upon Dr. Deepak’s practice serendipitously one afternoon as I walked through the migrant neighborhood in search of nearby medical options for women. Dr. Deepak oversees a small maternity clinic (called a nursing home in India) with five beds in the main room and two beds in a smaller, semi-private room. He reports seeing twenty-five to thirty birthing women per month, most of whom come from the migrant neighborhood. He had originally worked in a village, but once he completed his OB/GYN specialty he had to return to the city. “As a male gynecologist, I could not have worked in the village,” he told me. But he found that women in urban Jaipur did not have the same aversion to seeing a man for their reproductive health care. His son Dr. Vijay agreed: “One in 1000 women will refuse to have me examine them…. Otherwise I don’t feel there’s any hesitation, that women refuse.” As male obstetricians, Dr. Deepak and Dr. Vijay were rare in Rajasthan. I did not encounter any other male obstetricians working in either the public or private sector during my research.

Dr. Chandni, a postgraduate student in OB/GYN, provided an answer to my questions about gender concordance that went beyond comfort. She felt she could do a better job of treating women than a man could because she had some shared experience with her women patients: “If somebody’s having pain during her periods and she comes with that complaint I can understand. If the same patient comes to a male gynecologist, he may not understand the pain,
he’ll just cure the disease.” Dr. Chandni’s explanation touches on questions that have been asked in a plethora of social scientific studies: does gender concordance matter, or does the presence of women doctors improve healthcare in some tangible way? This research has told us much more about healthcare in the US than in India—indeed, in part because of vastly more research money available here, and in part because women doctors are a relatively new phenomenon in the United States and therefore an alluring topic of study. It is interesting to look at what researchers have (and have not) achieved in studying women doctors in the US. Quantitative studies search for differences in doctor-patient communication between men and women, finding some differences in communication style but no difference in measurable health outcomes—indeed, in other words, women doctors do not make their patients more or less healthy than do male doctors (Bertakis et al. 2003, Lorber 2000). Others claim that gender concordance between doctor and patient can make the patient feel more comfortable, leading to greater trust of her physician and allowing for greater empathy on the part of the physician (Boulis and Jacobs 2008, 136). And yet, studies of patient satisfaction based on gender concordance produce conflicting results: Boulis and Jacobs (2008) cite some studies that show greater patient satisfaction and some that find the exact opposite (Boulis and Jacobs 2008:142). Bertakis et al. cite conflicting studies of patient satisfaction based on the physician’s gender, with each study tending to find the opposite of the one that came before (Bertakis et al. 2003: 70).

Several underlying assumptions guide these studies: that it is possible to discern whether women make “better” or “worse” doctors than men; that women patients will be more satisfied with a woman doctor; and that women might bring something new and different—and potentially transformative—to the practice of medicine. These North American studies all presume commonality within the category “woman,” just as Dr. Chandni assumes a similarity
between her own menstrual pain and that of her patients, whose life circumstances are likely to be dramatically different from her own.

The idea that women doctors can better serve women patients was not limited to the colonial encounter in India, but could also be found during the women’s health movement of the 1970s and 80s in the United States. Second-wave feminists in the United States, recognizing bias against women in the American biomedical system, critiqued what they saw as an uneven power dynamic between male OB/GYNs and female patients. Many American feminists assumed that if more women entered positions of power within biomedicine this power imbalance would fade away (Altekruse and McDermott 1988, Corea 1988, Scully 1980). Women are filling the ranks of doctors in ever-increasing numbers in the United States; however, medicine itself has not been transformed into the woman-friendly haven earlier feminists desired (e.g. Davis-Floyd 2003, Jordan 1993). It is also troubling that the authors of many recent quantitative studies on the impact of women in medicine have shed the Second Wave feminists’ attention to power inequalities, effectively de-politicizing women’s position in the medical system. A power hierarchy remains in the doctor-patient interaction even when both doctor and patient are women; what matters is that they are different kinds of women.

**The Female Seclusion Paradox**

The intersection of Indian gender norms and colonial allopathic medicine produced something I call the female seclusion paradox. This paradox emerges from the conflicting requirements of female seclusion and male-gendered clinical medicine that generated two kinds of difference. First was the universalized difference between women and men that transcended cultural boundaries and required women doctors to treat women patients. Second was the difference
between women that the female seclusion paradox demanded. If the idealized Indian female patient was secluded, then a different kind of woman was required to move between the male-gendered allopathic world and female-gendered zenana. Two classes of women were thus produced through the introduction of allopathy into India: those who were secluded and in need of treatment, and those who must enter the male-gendered outside world of allopathy, overseen by male medical officers, in order to treat other women. This paradox is a historical product of the entrance of a male-dominated medical system onto the scene, one that claimed authoritative knowledge of women’s bodies and birth over and above what local birth attendants already had. According to this formula, women of the doctor class must be somehow different in order to escape the gender rules that shape the lives of others. British women, calling upon their difference from Indian women, positioned themselves as the champions of the health of their Indian “sisters.”

Butler (1990) decades ago pointed out the dangers of ignoring the differences between women – political, economic, ethnic, racial, national, sexual – to name just a few; these differences are often more important than any similarities based on gendered experience. Similarly, Mohanty (2003) warns of the trap of the “third world woman” that assigns similar problems and experiences to the women living in vast swathes of the world. Like Butler, Mohanty urges us to pay attention to difference. The female seclusion paradox leads us to consider similarity and difference simultaneously. The desire for gender concordance assumes that women are similar enough to justify a women-only health care apparatus. At the same time, the bodies of one kind of women are marked as in need of saving, while another kind of women become their saviors. The distinction between saved and savior requires the assumption of difference.
The female seclusion paradox will return throughout the dissertation as I look at women doctors in practice today, especially those who work in rural areas. Government health policy tends to see women doctors operating outside the system of gender relationships that inspires gender-based interventions in the name of women’s empowerment. Women doctors are educational elites and can position themselves as modern career women. At the same time, women doctors must work within gendered norms of family responsibility, proper movement through space, and interactions with strangers. They do not exist outside of contemporary Indian society.
Introduction

In this chapter I explore the ways in which medical training shapes doctors’ perceptions of medical work, particularly in the government sector. Although my focus is ultimately on one particular moment of crisis at the end of medical training, during which graduates have to decide whether or not they will take a rural posting, I also consider what students experience in the medical college on their way to this choice. Caste and gender mark certain students as different in the social dynamics of medical college, creating a hierarchy that was visible in students’ behaviors. Students are further marked along the process of medical training by their ability to enter a competitive residency program, or their failure – leaving them “just” a basic (primary care) doctor.

Indian medical colleges are often accused of preparing students poorly for primary care and rural work; indeed, I found a medical college culture that privileges specialization over primary care. In India most doctors have an MBBS degree (a terminal bachelor’s degree in medicine that trains them broadly in primary care) that carries with it less and less prestige as the opportunities for specialization grow. Students then spend the majority of their time studying for written exams that will allow them entry to a specialist program rather than learning the practical skills that are supposed to accompany an MBBS degree. Rajasthan harnesses this desire to specialize in order to address the shortage of rural doctors. If MBBS graduates spend a prescribed amount of time at a rural clinic, they receive a boost in their exam score. Yet, because rural work is not equally available to men and women for the reasons I discuss in this dissertation, men’s opportunities are privileged. Through the structure of medical education in
India, students are shown that hands-on experience is less important than studying for, and excelling in, written exams. All of the inertia of medical education barrels towards the PG exam upon which futures depend. When students do not get a PG seat on the first try, as happens in the vast majority of cases, they must decide what to next.

In this chapter I draw upon Wendland’s (2010) research on medical education in Malawi, along with a sizeable literature on medical education in the global North, to place Indian medical education in its unique context. Medical students in the global North largely take it for granted that the supplies and technology they learn during training will be available in their practice. In contrast, Wendland (2010) shows that the crippling shortage of resources and supplies at Malawi’s teaching hospital compels medical students to look beyond technical solutions for health care, turning instead to social and political advocacy and, in the process, developing strong emotional connections with their patients. During this same phase of training, medical students in Jaipur largely rejected the hands-on training they were supposed to receive as clinical interns. Instead of learning how to treat patients, students retreated to their textbooks to study for exams. The orientation toward exams and the prestige they bring does not bode well for the future of rural work, which, as I will argue in the next chapter, entails a loss of prestige for doctors.

**Becoming Doctors**

More doctors emerge from training every year in India than in any other country in the world. At the time of my research, over 40,000 students graduated each year with a basic medical degree in India\(^\text{32}\) - compared to only 18,000 in the US.\(^\text{33}\) The number of Indian medical graduates is increasing every year as new medical colleges open in both the government and private sector,
and as existing colleges petition to expand their student base. Although the number of students graduating from Indian medical colleges is roughly double that of the United States, the number of practicing doctors in the two countries is not much different. There were 938,861 doctors registered in India in 2013 (GOI 2015, 201). The US, with roughly half the number of medical graduates of India, employed 817,850 doctors in 2012 (Association of American Medical Colleges 2013). These numbers reflect the low density of doctors in India for the population, and also a “brain drain” of medical graduates from India to other parts of the world (Jolly et al. 2011, Kaushik et al. 2008, Mullan 2005, 2006).

In South Asia those who call themselves medical doctors can follow a multitude of paths toward practicing medicine: there are those who learned a bit from a relative, those who learned by doing, as well as those who have had varying levels of formal training (Banerjee et al. 2004, Das 2016, Das et al. 2012, Pinto 2008, Rao et al. 2012). In the highly regulated medical atmosphere of the global North, by contrast, medical doctors are made exclusively in the medical school. Like their American counterparts, with whom they often explicitly compared themselves, the doctors in my work all possess formal biomedical qualifications. Yet the way Indian doctors receive their qualifications, as well as the context they enter upon graduation, can be quite different from that of Euro-American spaces. Until recently the majority of research on formal medical training has come from the global North with little attention to how doctors are shaped through medical education elsewhere. Wendland (2010) offers the first major intervention into this lacuna with her study of medical education in Malawi, but I leave her work for the next section to begin with the history of anthropological and sociological interest in medical education.
Anthropologists and sociologists of medicine have shown a keen interest in medical school in the global North as the space where medical values, which must be taught to each generation of doctors, are on clear display. Early research on biomedical education came out of a sociological tradition and tended to focus on indoctrination into the role of professional physician. Merton (1957) supports this socialization process, finding the internalization of medical values crucial to keeping doctors from deviating from the “most appropriate kind of medical care” (Merton 1957, 78-9). In an ethnography of a Kansas medical school in the 1950s, Becker at al. (1961) see the students’ progress as a psycho-social phenomenon, asking how students cope with a grueling workload that includes pleasing fickle professors. In other words, how does one develop the right work ethic and social skills to make it as a doctor? Neither Merton nor Becker find much interest in what students learned; rather, they wanted to know how it was done. Nor do they question what the “most appropriate kind of medical care” might entail, and how it is contested.

Toward the end of the twentieth century scholars began look more critically at the results of medical socialization. In her work on obstetric students, Davis-Floyd (1987) shows how medical school limits ways of knowing about the body and its processes. Professors transform obstetric students’ beliefs regarding birth, teaching them to see birth as an illness event requiring medical and technological intervention to succeed. Using Van Gennep’s (1960) and Turner’s (1969) concept of the rite of passage, Davis-Floyd shows how students are isolated from society and slowly broken down through exhaustion, losing any of their humanistic reasons for wanting to enter medicine along the way. Through this process, students do not merely gain knowledge of medicine; they become obstetricians who have internalized the technocratic model of birth. Davis-Floyd perceives the end result of the rite of passage to be inevitable. She offers some
examples of “radical” obstetricians who have resisted the technological model of birth, but paints them as outliers, either entering medical school at an older age or being converted from the technological model through some sort of shock (Davis-Floyd 1987, 308). Davis-Floyd is deeply critical of the outcome of medical socialization – when alternative ways of knowing about birth become unthinkable for contemporary obstetricians, it is a loss for women and their health.

In these studies of medical socialization, the action tends to work in one direction: medical schools and the people who populate them (professors, administrators) pass on values, while the students are largely vessels, at least insofar as they have little control over the outcome. In their study of a new medical curriculum at Harvard, Good and Good (1993) try to disrupt monolithic renderings of biomedical knowledge transfer as they explore how knowledge is “literally constructed in the experience of the students” (1993, 84). They focus on tensions that arose as medical students learned to see like doctors. As they learned more about anatomy, students began to see diseased bodies as machines disassociated from their human selves, a technique of knowing described by Foucault (1994) as the medical gaze. But, as students reflected on how to be good doctors, they found themselves in a predicament: how can they be competent in their ability to diagnose and treat disease, a task that requires stripping away the patient’s personhood, while also being caring, a quality that demands a person-centric acknowledgement of suffering? The medical gaze still triumphs after these internal struggles, but Good and Good argue that the struggles bring valuable insight into a specific “medical world” (1993, 84), something particularly crucial if we wish to use North American biomedicine as a point of comparison with other places or other medical systems.

Anthropologists of medical education have recently turned greater attention to the creation of clinical subjectivities (Holmes et al 2011). This literature explores the doctor’s self as
it is created through active self-fashioning – that is, of course, constrained by various mechanisms of power (Foucault 1980). This is not a static, pre-formed self able to be discovered and “known,” nor one that is formed exclusively through socialization. In the context of medical education, “clinical trainees are not simply socialized and malleable, but are also active subjects who make choices, resist subjugation, accommodate power differentials, and use techniques to actively craft themselves internally throughout the process of becoming a new kind of professional” (Holmes et al. 2011). I focus on the creation of clinical subjectivities at a particular point in young doctors’ careers: at the end of the internship year, unless doctors are very lucky and manage to win a post-graduate seat, they must decide whether or not to enter government service in the form of an undesirable rural posting.

Although the literature on medical education has been theoretically important for the study of biomedicine, it has only been able to tell us what biomedicine was like in particular contexts (the research listed above all comes out of North America). While biomedical practice has reached every corner of the globe, its practice varies widely depending on local context and transnational capital flows (Lock and Gordon 1988, Lock and Nguyen 2010). Therefore, if the study of medical education is important for uncovering the “hidden curriculum” (Hafferty and Franks 1994) that relays the values of biomedicine to its next generation of practitioners, we need to expand our research into new geographic areas. In her research on Malawi’s national medical college, Wendland (2010) offers the first major study of medical education in the global South. Wendland compares her findings to the standard scholarly narrative of North American medical school enculturation, which she sums up as follows:

[The new doctor] has become technically skilled, medically knowledgeable, emotionally detached, cynical, convinced of her own status and authority; she is less the idealist who wants to help her fellow humans and more the technocrat who wants to do procedures on compliant bodies and be
handsomely paid for it. She sees individual biology and behavior as the root causes of disease and is blind to larger social and political concerns – or if not completely blind, she at least sees attention to such concerns as well outside her job description (Wendland 2010:18).

Wendland sees this narrative break down in the Malawian case. For instance, Malawian medical students do not get the chance to become technically proficient because once they enter their clinical training, the facilities necessary for them to put what they have learned in their pre-clinical years into practice are absent. Malawian students also do not experience the emotional detachment that scholars report from the United States; instead, Malawian students report developing more “heart” for their patients. This is in part because doctors find solidarity with their patients in the face of a common enemy: a corrupt and impoverished government that promises little to the health sector and delivers even less. Students in Malawi may memorize the same facts that American students do from the same textbooks, but they acquire different values as they come to realize the implications of practicing medicine in Malawi. Wendland crucially sets the self-fashioning of doctors into the broader political-economic context of Malawi. The global forces of structural adjustment and political corruption create a clinical crisis for students, forcing them to rethink both the logistics and the meaning of their work.

Wendland concludes that we cannot see biomedicine as a moral order made up of universal and unchanging medical values. Instead, she prefers the concept of moral economies, comprised of “a set of emotionally charged values used to negotiate changing economic and social relations between dominant and dominated groups… that are themselves open to negotiation and change” (Wendland 2010:196; emphasis in original). Wendland’s key point is that moral economies, in contrast to a static moral order, are “constantly re-created and renegotiated;” biomedicine, and biomedical values, are not static entities in either time or place (Wendland 2010:196). Her work confirms the utility of studying medical education in order to
understand the values of biomedicine more broadly. For Wendland, the moral economy of Malawian medicine begins to take shape during the clinical crisis, when students are faced with the nearly unbearable weight of work that must be done. In Rajasthan, the crisis upon which I focus comes slightly later, after graduation, when students are faced with clinical choices that are still largely imaginary for them.

In addition to Wendland’s concept of moral economies, I call upon Zigon’s (2007) use of the “ethical breakdown” in anthropological studies of morality to think through young doctors’ career crises. For Zigon, morality is the “unreflective mode of being-in-the-world” and ethics are “a tactic performed in the moment of the breakdown of the ethical dilemma” (Zigon 2007:137).

In other words, morals are simply lived without any thought, and they become ethics only when the individual’s attention turns to them.34 “The ethical subject no longer dwells in the comfort of the familiar, unreflective being-in-the-world, but rather stands uncomfortably and uncannily in the situation-at-hand” (Zigon 2007:138). For Zigon, doing ethics is motivated by being able to return to the familiar world where right and wrong are clear – not by trying to “be good” all the time. Zigon’s distinction is useful in drawing attention to the moment of crisis (as Wendland likewise does). For women doctors in Rajasthan thinking about entering government service, this crisis comes when career aspirations, ideals of community service, and gendered discourses of risk collide. Medical graduates must then renegotiate what it means to be a good doctor and a good woman.

Ruddock’s (2017) study of the All India Institute of Medical Sciences (AIIMS), India’s leading government medical college in Delhi, continues Wendland’s project in a very different kind of institution. Since its inception AIIMS has boasted India’s most cutting edge medical technology and research, and confers upon its doctors unmatched prestige. Although the opening
of India’s economy has brought increasing competition from corporate tertiary hospitals, AIIMS continues to attract patients from across the country, drawn by its reputation and affordability. Ruddock argues that, because of AIIMS’ long-held position as the top medical college in the nation, the institution has largely set the agenda for medical education across the region. AIIMS students expect to complete post-graduate degrees and to work in urban centers – AIIMS does not train students to work in primary care. For Ruddock, AIIMS represents the inherent challenge of an institution founded to reflect Indian parity in the global discourse of scientific progress while sensitizing skilled clinicians to the needs of their poorest fellow citizens. It is this postcolonial modernity, with its often uneasy encounters of people and ideas that informs both imagination and practice at AIIMS, feeding in turn students’ perceptions of exemplary medicine (Ruddock 2017:263).

Ruddock borrows the terminology of one of her informants to argue that “AIIMS killed the GP [general practitioner]”, despite the population’s need for general doctors (Ruddock 2017:233). Even in more provincial Jaipur students expected to specialize; as I show below, becoming “just” an MBBS doctor is no longer acceptable to the majority of students. And yet, the majority of students will have to settle for “just” an MBBS. This tension weaves its way through my entire dissertation as I examine how students adjust to career opportunities that look quite different from their career aspirations.

**Mahatma Gandhi Medical College**

My entry into medical education in Jaipur came mostly from one of the city’s two private medical colleges, Mahatma Gandhi Medical College (MGMC). MGMC sits in a sparsely populated industrial zone on the outskirts of Jaipur, the very last stop on the bus line from the heart of the city. Several other newly opened colleges teaching engineering or business rise out of dusty fields along the road. At the final bus stop, the last few passengers unload – a white-
coated student or two, plus a few patients headed for the hospital. The main building glitters beyond the front gates, walls tiled with reflective glass. A statue of Mahatma Gandhi dressed in a homespun dhoti, clutching a walking stick, towers incongruously above a dry fountain in front of the hospital’s shining façade. Several men sit on whitewashed curbs that line the hospital’s driveway, and patients’ relatives have hung their freshly-washed saris up to dry along a short stretch of fence lining the hospital’s outdoor canteen. But these few people can hardly be considered a crowd, the unavoidable reality at public hospitals like SMS in Jaipur or AIIMS in Delhi.

MGMC is part of a larger trend of the privatization of medical education in India. New colleges pop up every year in an attempt to fill impossibly high demand for medical training, and the vast majority of these are privately owned by a “trust” that, ideally, should not be generating profits. Between 1990 and 2014, the number of private medical colleges in the country increased by 405 percent (Choudhury 2016). One problem with the speed of new college development is that, due to lapses in oversight by the Medical Council of India (MCI), colleges manage to gain accreditation despite glaring problems in their ability to train students (Ananthakrishnan 2010). Many Indian medical colleges fail to attract enough faculty to fulfill teacher-student ratios mandated by the MCI, with newer colleges finding the task especially difficult; one editorial opined that “the student-teacher ratio in most of the private colleges is pathetic” (EPW 2011). In addition, newly-opened private colleges require a critical mass of patients filling their hospital beds in order to have what is commonly, and rather coldly, referred to as “clinical material” (Ananthakrishnan 2010). Medical students need to be exposed to a wide range of patients with a wide range of ailments – which presents a problem for a hospital like MGMC, situated in a relatively uninhabited area of Jaipur and lacking the reputation of SMS.
Ruddock (2017) sees the patients that flood AIIMS in Delhi as “simultaneously a hindrance to efficient practice, and a bioavailable resource enhancing the institution’s reputation for comprehensive training” (p. 198). The thousands of patients who line up to see AIIMS doctors in Delhi, or SMS doctors in Jaipur, only enhance the reputation of these institutions as desirable hospitals and medical colleges. MGMC, on the other hand, had to work to recruit enough patients to keep Medical Council of India inspectors happy – and to present students with the “clinical material” they needed to learn medicine. MGMC tries to mitigate the lack of patients by essentially running two hospitals in one: there are general wards, offering the same services for the same prices as a government hospital, and luxury paid wards, which, along with student fees, finance the hospital and school. If a woman comes to MGMC to give birth, she can pay to have a semi-private or private room, or she can labor for free in a room with six beds and recover in the general obstetrics ward with approximately thirty other women. According to a hospital administrator, the hospital covers the costs for delivery (including cesarean) in the general ward. MGMC’s website lists the different rooms available along with their daily prices, ranging from free in the general wards’ dormitories, to Rs. 4000 ($63) per day in a private suite. This scheme worked well enough to keep patients in the hospital, at least in the obstetrics ward where I spent most of my time. Hospital records for 2013-14 show an average of eleven normal deliveries and two cesarean sections per day. There were no crowds of would-be patients waiting their turn for a shortage of spaces as is too common in government hospitals, but the ward was mostly full most of the time.

Private medical colleges in India are set up as trusts and are not technically supposed to be profit-generating institutions. Institutions of higher education (including, but not limited to, medical colleges) administered by trusts receive special privileges from the Indian government in
return for providing a service to the community. In practice, by charging large “capitation” fees for admission, many private colleges bring in big money. The capitation fee is a one-time under-the-table charge to students, essentially buying the student a seat in the medical college. Although the Supreme Court has declared the capitation fee illegal, it remains “an open secret that many colleges continue to charge this fee with impunity” (Choudhury 2016, 73). The illegal, and therefore unregulated, capitation fee ebbs and flows with market demand. In 2014, the Medical Council of India, the board that oversees medical education, cut over 6,000 MBBS seats in private colleges, citing a lack of required infrastructure or faculty (Pathak 2014). This shortage, and the increased demand for fewer seats that resulted from it, allowed many private colleges to raise their capitation fee. Capitation fees range from Rs. 25 lakh to Rs. 50 lakh ($39,700 to $79,400) according to one estimate (Pathak 2014) and up to one crore ($158,700) according to another (Rao 2013); this one-time fee is in addition to the yearly tuition that can range from Rs. 2 lakh to Rs. 11 lakh ($3,000 to $17,500). In contrast, government colleges charge in the neighborhood of Rs. 11,000 ($174) per year (Pathak 2014). Based on this range, students would pay a minimum of Rs. 35 lakh ($56,452) and a potential maximum of Rs. 105 lakh ($169,355) for a five-year MBBS degree at a private institution.

Students at MGMC could not help but compare their own situation to that of nearby SMS, a school that offers greater prestige and far less debt than MGMC. I sat with three MBBS students in the school canteen one afternoon as they bemoaned the high cost of tuition – they told me it had suddenly jumped from 2.9 lakh per year to 6 lakh. Pratibha told me that this increase was illegal and would be challenged in the courts. In the meantime, however, students had already paid some of that money and were unlikely to see it again. These three students did not agree with the literature that questions the quality of education at private colleges. Pratibha
compared SMS with MGMC: at SMS, “the whole day [students] go out, no one has come to
teach, everyone is having fun, is sleeping, but here it’s not like that. You come to our class,
always full, the teachers aren’t usually late, everything gets taught…” Pratibha’s friend Jaya
chimes in: “and the responsibility is there, they have to complete the course. [The professors]
can’t say: you study on your own.” The implication is that, with costs at MGMC so high, no one
can afford to fail their exams and have to repeat the year. While chatting with another group of
MBBS students, Neelam, showing excellent school spirit, told me that MGMC was the best
medical college in Rajasthan. Her friend Aditi seemed surprised at this assertion, saying “what
about SMS?” The more assertive Neelam had the last word, calling SMS’ hospital “smelly and
crowded,” but Aditi’s point that SMS is actually better hangs in the air at MGMC offering
constant implicit comparison.

MBBS students generally wear white coats ("aprons"), carry backpacks, and move in
small groups. They are young, fresh out of high school. I watch them shuffle from the OB/GYN
outpatient department to the ward and back again in search of someone to tell them what they are
supposed to be doing. The schedule posted on the wall never seemed to match what was actually
going on; this bothered me far more than it did the students, who took it all in stride. Informal
leaders emerged from each group of students who tasked themselves with finding out where they
should be for the day’s activities. The resident or professor who was assigned to them that day
might have more pressing responsibilities elsewhere; lectures could be cancelled at the last
minute and shifted to a history-taking assignment, or a dismissal to return home and study. I got
lucky one day when I came across Neelam and Aditi working on a clinico-social history-taking
exercise under the guidance of Dr. Kamlesh, an unusually earnest resident in the preventive and
social medicine department. Their patient was in the women’s medical ward with neck pain. First
they hesitantly approached the right side of the bed, but could not fit – the patient’s mother was
lying down on a bench between the beds. They conferred: doctors are supposed to approach from
the right side; was it ok to do it from the left? Yes, said Dr. Kamlesh. The patient cooperated
through a list of hastily translated questions about her family income, her job, and her living
conditions. When they reached a long list of diseases that they struggled to translate from the
English questionnaire, the patient snapped at them. “TB! You think I have TB? No, I have had
nothing. Other than the neck pain I’m totally fine.” As we walked out of the ward Neelam
mimicked the woman for laughs: “TB?! I don’t have TB!” she said as the two students giggled
together. In other contexts, Neelam struck me as an unusually thoughtful and sensitive student.
Later, as we revisited the interaction, Neelam expressed her frustration with what she saw as this
patient’s lack of respect for her. “They [patients] think we are just doing time-pass with them,”
meaning killing time by asking them questions over and over. Neelam felt that the clinico-social
history serves an important purpose – it ensures that they have a complete and correct
understanding of the patient written up in her chart (only not in this case, as their history-taking
was interrupted by the woman’s temporary transfer out of the ward for tests). Neelam’s efforts to
do well on the exercise that had been assigned to her were thwarted both by the patient, who was
willing to humor the young medical student only up to a point, and by the choices of those who
were responsible for the patient’s recovery, who decided she needed to have more tests.

I was surprised at how difficult it was to do this kind of observation in the medical
college. While I had the grudging permission of the heads of the OB/GYN and Preventive and
Social Medicine departments, I did not have their active support. I was on my own to approach
doctors and students, some of whom welcomed me and some of whom did not. MBBS students,
who had the least responsibility in the hospital, were generally the most willing to have me trail
along. But the difficulty of figuring out what they were supposed to be doing each day was a wild goose chase for all involved. Many of the times that I met students in the OB/GYN department they ended up signing themselves in to get attendance points and then going home.

Hands-on training begins in the fourth semester, which Neelam and Aditi were in the thick of when I met them. What I saw of this training seemed haphazard, dependent on whomever had been put in charge that day and how busy they felt with their other duties. My observations in the medical college reinforced much of what I was hearing from professors that, at least during this stage of training, the discipline of medicine is about reading, memorizing, and taking exams. More intensive clinical training is supposed to take place in the fifth and final year of medical college, termed the internship. Again this training is largely supplanted with studying from books – a phenomenon I explore further below.

Caste and Hierarchy

Caste-based reservations for higher education make caste a visible form of hierarchy at the medical college. Each year’s admissions lists, along with who was admitted under which caste category, are publicly available on MGMC’s website. Students know each other’s caste category, at least as it fits into the four different groups used for reservations. These groups are: general, or upper castes; scheduled castes (SC); scheduled tribes (ST); and “other backwards classes” (OBC). Reserved seats for SC and ST groups in higher education were protected in the First Amendment to India’s constitution in 1951. In 2006, the central government added OBCs to the list of higher education reservations in universities that receive public funding (Hasan 2009). Despite its status as a private college, MGMC also complies with the state reservation law. Following Rajasthan state law, MGMC reserves twenty one percent of seats for OBC, sixteen
percent for SC, and twelve percent for ST categories, with the remaining fifty percent ostensibly left open to anyone but usually filled by upper-caste applicants (underlining the continued need for reservations to maintain diversity in higher education).43

Despite the visibility and salience of caste, at least in terms of getting a coveted MBBS seat, caste was a difficult subject to delve into ethnographically. I found upper-caste students ready and willing to talk about caste, as long as they were surrounded only by other upper-caste students. These students often brought up caste-based reservations themselves in our conversations. For example, Pratibha, Jaya, and Aditi, who all came in through the general category, complained about what they felt to be double standards in admissions for different groups. They compared scores on their entrance exams, all near the ninety-fifth percentile; they thought that students in the reserved categories only needed to score around the seventieth percentile to be accepted. The goal of entrance exams is to score well enough to gain a spot in a government college; those who cannot, but have money, are forced to settle for a private college. As Jaya said, laughing: “if we were SC/ST, then maybe we would have gone to SMS. Just because we are in the general category, we have to go to Mahatma Gandhi!” Casteist ideology about who deserves seats in the medical college and who does not slips all too easily under the veneer of meritocracy, which seems to be an acceptable way to talk about caste, at least among upper-caste students. Students and doctors who disapprove of reservations, especially for the newest OBC group, are vocal about their dislike in public ways – epitomized by the protests that have accompanied the increase of reserved seats for disadvantaged groups.

When reservations in higher education were extended to OBC communities in 2006, large groups of students and doctors at AIIMS, along with other prominent medical colleges throughout the country, protested the decision. The AIIMS administration backed the anti-
reservation protestors, overlooking their presence and possibly actively assisting them (Thorat et al. 2007). In contrast, the administration was quick to shut down pro-reservation rallies. Following this scene of bias in favor of upper caste interests, the national government formed a group – the Thorat Committee – to investigate caste-based discrimination at AIIMS. The Thorat Committee found evidence of discrimination against SC/ST students in educational opportunities, housing, and social life. They concluded that quotas on their own are not enough; SC/ST students and faculty need further support from the administration in order to thrive in what has long been an upper-caste dominated institution. Indeed, reservations are often held to impossible standards for improving the socio-economic status of groups of people. Deshpande (2013) argues that “so great is the emphasis on reservations that the policy acts like a giant magnet dragging virtually all discussions about social justice and equality of opportunity into its force field…. Reservations, especially in higher education, can only provide protected entry or formal inclusion – they cannot deliver social justice” (p. 14). Reservations reserve seats for particular groups in medical college admissions, but they do not guarantee success, graduation, or a fulfilling career. Upper caste Hindus still dominate the ranks of medicine. In 2004-5, a study of degree holders living in urban India found that upper caste Hindus made up fifty-nine percent of medical graduates but only thirty-three percent of the population. SC students made up seven percent of medical graduates but fifteen percent of the population (Deshpande 2013, 19).

Of the 18 MBBS students from MGMC and SMS whose caste status I had access to, 13 were admitted through the general category, four through the OBC category, and one through the ST category. My random sampling technique, based on approaching students in the hallway and hoping they were willing to talk to me, coupled with my shift in focus away from the medical college and towards rural fieldsites, kept me from including more SC and ST students in my
research. This absence is a flaw that I hope to remedy in future visits to Jaipur. Although the voices of students from SC and ST groups do not play a prominent role in these pages, the ways in which students from upper caste groups talk about SC and ST students show that caste is divisive in the medical college. Most often, I heard conversations about caste in terms of reservations and meritocracy, as in the conversation above with Pratibha, Jaya, and Aditi. My attempts to interview one student, who I later found out belonged to an ST group, show a different layer of casteism further cementing the differences between an upper caste “us” and a lower caste “them.” I had approached intern Dr. Neha in the hallway outside the OB/GYN department and chatted with her in Hindi, asking if I could interview her sometime later. She seemed friendly and interested; I filed away her number. Later I ran into her outside the canteen while I was sitting with Dr. Anil, an intern who had taken it upon himself to try and help me find people to interview. Dr. Neha was walking past us into the canteen when Dr. Anil called her over. She was not at all friendly in this interaction, and I thought maybe she didn’t like Dr. Anil, or I had somehow stumbled into some social awkwardness (I still knew very little of who hung out with whom in the social minefield of college life). Anil later told me that he had also noticed Dr. Neha’s reluctance to talk to us and he asked her about it. According to Dr. Anil’s account, Dr. Neha didn’t want to be interviewed because the first time we met I had asked her inappropriate questions. I immediately racked my brain to figure out what I could have said to her; I only remembered her laughing at the foreigner who speaks Hindi as we exchanged pleasantries (which was more likely Dr. Neha trying to giggle away the awkward situation I had created). Misunderstandings are inevitable in a place where I do not understand subtle social cues. When Dr. Anil went on to say that Dr. Neha was from an ST group, which I did not know when I approached her initially, I told him I was even more upset because I specifically wanted
to talk to students who were admitted through reservations. “Well, you saw what they’re like,” was his response. His short phrase was bursting with meaning: “those” people were conservative, easily offended, and not cosmopolitan enough to interact with a foreign researcher. I began to worry anew that Dr. Neha had changed her mind about the interview because I was suddenly associated with Dr. Anil.

I asked Dr. Anil if students of different caste backgrounds hung out together at the medical school. He said that there was “groupism: people from similar castes, they have their own groups. So Jats [community listed as OBC] will have their own group, and Meenas [community listed as ST] will have theirs.” In contrast to Dr. Anil’s description of college social life, Neelam, who was admitted from the OBC group, said that her social life was completely “mixed.” Shilpa, an MBBS student at SMS, reiterated Neelam’s statement. Shilpa, who came in under the general quota, has a group of close friends where each person is from a different caste category. She was very proud of the diversity of her friends – yet maintained a post-caste position on reservations, arguing that the various groups had advanced and no longer needed what she felt was preferential treatment.

MGMC brought diversity into student life, possibly inadvertently, by grouping students into units alphabetically based on their first name. These small units attended classes together, went on rounds together, and completed hands-on assignments together. I met up with intern Dr. Shireen at MGMC’s Rural Training Center and found three others from her alphabetical group alongside her. The issue of reservations came up and I immediately jumped in to ask them what they felt about it. Dr. Shireen answered, echoing what Shilpa at SMS had told me, that previously there had been a benefit, but now those groups were “developed” and no longer needed reservations. She felt that it would be better if reservations were class based rather than
caste based. Dr. Subhash added that the issue of reservations had become a vote bank – politicians procure reservation status for a group so they can get their votes. While this conversation was taking place, Dr. Sushila slipped out of the room. Dr. Shireen noticed, and said quietly to me: “Sushila came in under a reservation – she’s ST. Maybe she’s uncomfortable.” We changed the subject and eventually Dr. Sushila returned. When I asked Dr. Anil if there were people from different caste groups in his social group at the college, his first response was “yeah, I’m open-minded. Caste doesn’t matter if we have things in common.” But after thinking for a while longer he admitted that most of his friends were from the general category. The amount of time they spend complaining about caste reservations would lead to impossibly uncomfortable situations in mixed-caste social groups.

I did not learn of explicit caste-based educational discrimination at MGMC – although this does not mean that I can dismiss the possibility of its existence. What I definitely did see was evidence of caste discrimination couched in the language of merit and opportunity, which rippled outward into social interactions and shaped friendships. It is clear that reservations save the medical college from the potential of homogeneity, and they force interactions between different groups, whether or not those interactions serve to reify group boundaries.

With all the complaining about caste-based reservations I heard from upper-caste students, I thought they might be more likely to choose the private sector since it offered (according to the rhetoric of meritocracy) a more even playing field unhindered by government intervention. Government service uses the same system of caste-based reservations as higher education. In my small sample I did not find any correlation between caste and preference for the private sector. The two students who expressed a preference for the private sector were both from the general category, but so were the majority of students who wished to work in the
government sector. In my limited fieldwork time I was not able to dig more deeply into the connection between caste and work in the government sector, but this represents an interesting area for future research.

I want to touch on another type of difference that was in short supply at MGMC because of the college’s high fee structure: that of economic diversity. Dr. Shireen thought that reservations would better serve those who most needed them if they were based on income rather than caste. Dr. Shireen felt she was different from other students because of her economic problems: “Here everyone is only rich. It seems to me that I’m the poorest person in my class.” Dr. Shireen’s tuition was paid by a group of doctors who are trying to educate more women from her Muslim caste group and to bring a woman doctor into her community. Dr. Shireen’s background is unusual, and creates tensions between her career ambitions and her sense of loyalty to her home community; I delve more deeply into these tensions, as well as issues of socio-economic class, later in the dissertation. The vast majority of students at MGMC, however, are there because they have unusually large financial resources from which to draw.

**Gender and Specialization**

Neelam, a second-year medical student at MGMC, wanted to become a cardiologist, but tried to be realistic about the rocky road ahead of her. During an interview, Neelam laid out an impressively comprehensive list of the kinds of cooperation that would make it possible for a woman cardiologist to thrive in India. Her theory of cooperation began in the operating room with other medical staff – “because there’s never a single-handed operation” – and moved on to other social relationships. A woman needs the cooperation of her spouse, her in-laws, and her children in order to put in the long hours. She also needs help getting around, because “in India
you can’t go out alone at night, you need a person with you.” Neelam’s theory of cooperation
also references patients. If a patient sees two cardiologists and one of them is a woman, he will
think “she must be weak, she can’t do the work, she can’t get into long hours of surgery, she
would be tired, she’s a mother, she has to do the housework, she can’t do that.” Neelam planned
to leave India for the United States, where she felt people would “cooperate” with a female
cardiologist. Neelam envisioned the US as a place where a woman cardiologist could have
freedom from restrictive social relationships and dangers such as sexual harassment, and where
a woman cardiologist could command respect. Like Neelam, women doctors and medical
students were keenly aware of their position straddling, on the one hand, a career that was
deemed highly appropriate and respectable for women, and on the other, a career that would not
be easy for them as women. The US became a point of comparison for Neelam as she organized
her list of grievances against Indian society for holding her back. Toward the end of my research
period, Neelam told me with an air of defeat that she had changed her mind – she would try for a
PG in OB/GYN instead. This would simply be easier; she was tired of going against the grain.

Sagar (2009) conducted a survey of women specialists practicing in Delhi in 2000. Forty-
five percent of women specialists were in obstetrics and gynecology, and none were in
orthopedic surgery – deemed the most masculine specialty. Furthermore, Sagar found that
“women who decide to go into male dominated disciplines very often have to face overt as well
as covert discrimination…. Not only are women often told to keep to their ‘fields’, many may
face rude, aggressive and threatening behavior from male colleagues as well as slurs on their
characters” (2009, 269). Although this did not come up often among medical students (Neelam
was unusual in overtly foregrounding gender in her career plans), a few of the doctors I met
corroborated this, agreeing that aggressions come from colleagues and supervisors as well as patients.

Even if women remain MBBS doctors and general practitioners, as the majority will, it is assumed that they will care for the female population. This becomes a kind of specialization, although not one that confers the status of a postgraduate degree. Even those who specialize in something different from OB/GYN are assumed to be “lady doctors,” meaning they are de-facto specialists in women’s health. Dr. Usha, a postgraduate student in preventive and social medicine whom I met in Delhi, had worked for a while in the field studying infectious disease outbreaks. She disliked it when people assumed she practiced women’s health – and, in her experience, this happened often. At the same time, she preferred to treat women patients because they showed her respect. For her this respect (or lack thereof) was exemplified in their term of address: men often referred to her as “bahan” (younger sister), a term often used for nurses, while women called her “Doctor” or “Madam.” Women’s health care remains the most well established place for women doctors, where they can do their job with relative ease and do not have to fight for the respect of colleagues and patients.

*Easy Choices*

The first thing I learned upon asking medical students about their entry into medicine is that, for most students, medical college is hardly a “choice” in the sense that a young person feels a particular affinity towards practicing medicine and then decides to sit for the medical entrance exam. Students who were high achievers from a young age were expected to go into one of the two most competitive fields in India: engineering and medicine. The choice, then, might be a narrow one between which of these two options best suited a bright and resource-rich young
student. Furthermore, parental input loomed large in students’ accounts of their path to medicine. According to Dr. Kanta, a first-year medical officer in Vijaynagar CHC, “at the start there was not any aim or target. I am a good intelligent girl, good at studies, and my parents said ‘she will become a doctor.’” Dr. Kalpana, an intern, said: “actually, my father wanted it. I wanted to become an engineer, but I followed his wishes. But now I have come around to it. A doctor gets respect in society, and also there is good earning.” Some did speak of a passion or desire (one doctor said that medicine had been her “hobby” since she was a little girl, sticking band-aids on dolls). Shilpa, an MBBS student at SMS, recounts her path toward choosing medicine:

Before I thought I would become a teacher, in my young childhood…. Then after that I thought I will become an actress. So I asked my father’s older brother, my Tao-ji, and he said that we people don’t become actresses. Then after this I began to think of being a doctor. I did coaching, and I indeed had to become a doctor. When I found my head, then I started to think about being a doctor!

It is not difficult to cultivate a passion for such a socially appropriate career; students are hardly rebelling by following their hearts into medical college.

Shilpa’s statement above also highlights how one’s background can provide an easy path toward medicine. She came from a biomedical family: both her parents, along with her older brother and sister, were doctors. Shilpa’s uncle made it clear that “we people,” coming from a respectable family, don’t become actresses; a career in which a woman presents her body for the visual consumption of others is not one that “good” girls are supposed to pursue. Her family steered her toward a more acceptable career. In contrast, intern Dr. Shireen came from a family where there were no doctors. Her mother and her father’s sister were both illiterate. She told me that girls from her village did not pursue higher education at all – she was a pathbreaker in merely attending college, let alone entering the high prestige career of medicine. As in Shilpa’s case, medicine is a career that her parents could be proud of. Medicine, along with engineering,
is seen as an ideal way to maintain one’s social position or move up on the socio-economic scale. According to Hasan, “elite institutions like the Indian Institutes of Technology (IITs), Indian Institutes of Management (IIMs), and medical colleges are in great demand from various sections, most notably the upwardly mobile middle classes, because these institutions provide heavily subsidized high-quality education which can fetch a good job anywhere in the world. These institutions are under enormous social and political pressure from all sides because they are the principal avenues of upward mobility for everyone” (Hasan 2009, 97). The promise of social mobility (or at the very least maintenance) places incredible pressure on higher education in general, and medicine and engineering in particular, to provide opportunities for young people and their families.

“We Don’t Go To a Basic Doctor”

All of the MBBS students I interviewed, even the rare few who were not opposed to rural service, said that they would sit for the post graduate (PG) exam at least once. The PG exam shaped the internship, the final year of medical college, when students were supposed to rotate through departments to get hands-on experience. Most students agreed that studying for the PG exam during this final year was more important than actually attending the internship rotations. One of the rotations that particularly interested me was the Rural Training Center (RTC) in Vatika, a village just outside Jaipur city limits. Vatika was only ten kilometers from MGMC and could be reached in twenty minutes if you had your own transportation; the same trip took up to two hours if you had to travel by bus or by “Magic,” the model name of small white vans that offer private transport in suburban areas. The purpose of the RTC was to expose students to a typical primary care facility in rural Rajasthan. In practice, the RTC was nothing like the PHCs
that freshly minted medical officers would encounter as they entered government service. I visited Vatika four times, checking in on the RTC as well as Vatika’s government PHC down the road run by a husband and wife doctor couple who were well-established in the community. While the PHC was busy every time I visited, the RTC was nearly always empty. The RTC building was lovely – spacious and clean and airy – and eerily devoid of either students or patients. One December morning I arrived at the RTC to find Dr. Rakesh, a resident in preventive and social medicine, overseeing operations – although it looked suspiciously like nothing was happening. I had come looking for interns so I could ask them about their experience working in the RTC, but there were no interns to be found. Dr. Rakesh went down the attendance list calling each intern currently assigned to the clinic, telling each that the president of MGMC had sent someone to interview them. This was not at all how I would describe my position as researcher, but it had the effect Dr. Rakesh intended: in about half an hour, five young men showed up atop two motorcycles. Dr. Rakesh sat them in a room together and I proceeded to conduct one of the more awkward focus groups of my research career, with Dr. Rakesh overseeing the proceedings and no doubt adding to the terrified formality of responses that greeted my questions.

Professors differed in their orientation to the internship experience. One middle-aged professor, whom I found one morning at the RTC enjoying a leisurely cup of tea – again there were no interns present – gives the students a lot of leeway. He understands the importance of the PG exam for students’ careers. Dr. Pratiksha, a young preventive and social medicine professor whom I met on a shift at MGMC’s urban equivalent to the RTC, was unusual in that she required that her interns show up, on time, for the entirety of their rotation. It is hard to ask your students to do much more when there are no patients, and therefore no diagnosis or
treatment, to observe. During my two visits to see Dr. Pratiksha at the Urban Training Center, I found the interns sitting around a table studying textbooks and quizzing each other.

Working in a PHC in rural Rajasthan did not require post-graduate training; medical officers were primary care doctors who prescribed drugs, performed triage, steered their patients toward biomedically-approved behaviors, and, ideally, although not always in practice, offered services for uncomplicated births. In the world of public health, this is an incredibly important rung in the ladder of care – primary care doctors are there to keep patients with more minor complaints from flooding secondary or tertiary hospitals. Ruddock (2017) found that students at AIIMS all planned to do specialist residencies (and most were interested in super-specialties as well). This is not surprising as AIIMS attracts the top students in India; however, as I mentioned previously, Ruddock argues that AIIMS sets the standards for medical education and medical aspirations throughout the country. I came to Rajasthan precisely because I was interested in primary care doctors, and I hoped to find more students who envisioned themselves in primary health roles than I had found during preliminary research at more prestigious medical colleges in Delhi. But the AIIMS trend was evident among the students I interviewed at MGMC and at SMS. Some students were resigned to working in a PHC, but not before trying the PG exam at least once.

JK: So you definitely want to do PG?

Dr. Sandhya (intern at MGMC): Yeah, for sure. Becoming a medical officer is simple as compared to clearing the PG. So people think that if we clear the PG, we can get better job options, better money.

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JK: Why do you want to do PG?

Dr. Disha (intern at MGMC): No one wants to be a basic doctor. We need to do further studies. Even if we’re sick, we go straight to a specialist – we don’t go to a basic doctor.
JK: If nobody wants to be a basic doctor, whose responsibility is it to care for the basic needs of the population?

Dr. Disha: Look, not everyone will get into PG. In fact the majority will have to become basic doctors.

Becoming a career medical officer, then, seems more like an admittance of defeat than a desire to work in primary care. It does not bode well for rural primary care if the rural posting is either a stepping stone to greater things or a space to live out one’s unfulfilled career aspirations.

I attended a class in MGMC’s Preventive and Social Medicine department where second-year MBBS students were presenting on a research project they had done in Vatika. Out of thirty students in the class, only two had gone to the village to conduct their survey; those two presented their findings to seven professors from the department (six men and one woman). None of the other students showed up. The two young women who did participate only interviewed one family each, making their survey data, as one of them put it, “laughably inaccurate.” I chatted with them as we waited for the professors to arrive, and they worried about having to present flawed data. “So if we say one hundred percent of the survey respondents lived in pakka (brick) houses, that’s wildly misleading. It just means that the two families we happened to talk to did.” Still, they formally presented their results to the small audience as if they were real and meaningful; it seemed important to go through the motions. The professor who led this exercise had a lot to say to me about the state of medical education after the presentation. According to him, the students are “exam-crazy.”

The students need to get practical experience, so they can feel what it’s like to practice medicine in the community. This is why we send them out to Vatika to do this survey. We want them to know what it will be like, to feel what it will be like. But they’re not interested in going. The students study at night and sleep during the day. Or they spend their time sitting in the AC library. They don’t want to go out to a village in the heat.
Few could argue with his main point: the students were exam-crazy. Not because they were lazy, but because the system required them to worry incessantly about their exam scores rather than their practical knowledge.

This professor echoed Disha’s point that, whether they like it or not, most MBBS graduates will end up as basic doctors. “We [in preventive and social medicine] tell the truth, but they don’t want to hear it – the truth is bitter.” From his perspective, India needs family practitioners, not super-specialists. He felt that social and financial pressures pushed students to do PG studies, but called this a “wastage of resources.” The infrastructure of medical education, theoretically ready to give students hands-on skills, is lying unused. When his department tries to train students in the skills they need to be family practitioners, yet none of them are interested, it is frustrating. And it is not hard to see how the provision of primary care will suffer.

Despite the murmurs of dissatisfaction I heard from some students and professors, students at MGMC are transformed into doctors and go on to productive careers in medicine. I asked intern Dr. Mohan if he thought he had received a good education at MGMC. “I’m mostly satisfied on the theoretical level,” he replied. “But in the fieldwork sort of thing, I’m not as satisfied.” He went on to explain that, because MGMC is private, there are simply not enough patients in some of the departments for students to learn from – the “clinical material” required by the Medical Council of India (MCI) for accreditation. During the interview where Dr. Mohan was explaining this to me, he got a phone call from a friend. They were discussing what documents they would need to register themselves with the MCI and begin practicing medicine now that their internship was finally completed. Just before I left the field, Dr. Mohan took a part-time job with a local NGO where he could work while he studied for his PG exam. Knowing about his earlier assessment of the hands-on training at MGMC, I was anxious to hear about how
it went. Two weeks later, sitting in Dr. Mohan’s living room while his mother cooked dinner, he told me he had been nervous and unsure of himself before the first patient came. But this feeling was fleeting. He found that he did know enough to treat the patients in front of him, or at least to refer them to the closest government hospital if he did not have the resources to help them. For Dr. Mohan this was an incredible feeling, to have this knowledge and to be able to treat people – it left him “flying high.” Many other interns from MGMC were doing similar contract work while they studied for the PG exam. I began to see this period as an unofficial extension of medical training. The hands-on experience did come, just not within the confines of the official medical college curriculum.

Generations

Indian public health rhetoric tends to frame the shortage of doctors as a conflict between the needs of the Indian population and the desires of medical graduates (Jayaram 1995, Mullan 2006, Lahariya 2007). While it could be argued that the health care “needs” of India’s rural population have never been adequately met by doctors who have always tended to cluster in cities, the discourse of needs vs. desires has only intensified following India’s economic liberalization. The post-liberalization generation of young people, dubbed “liberalization’s children” by Lukose (2009), are popularly seen to be acting only in self-interest and guided by consumption. “Liberalization’s children” is a riff on novelist Salman Rushdie’s “midnight’s children,” the generation born at the stroke of midnight on August 15, 1947, when India gained independence. The “midnight’s children” generation grew up alongside the Indian nation in a period when socialism and economic isolation dramatically constrained the type of consumption that was possible. These two generations are compared in the popular imagination: the older generation,
guided by a strong work ethic and a tendency toward simplicity; the younger generation, led astray by an increasingly available array of consumer goods. The choices some medical graduates make – to enter the urban private sector, to avoid rural service, or to leave the country altogether⁴⁶ – become more evidence of a generational moral decline. Baru (2010) interviewed retired AIIMS doctors who compared their circumstances in the mid-twentieth-century government sector with those of recent medical graduates. Looking through rather rosy-hued lenses, these doctors saw themselves primarily working for the good of the nation throughout their careers. Baru argues that an influx of money into the private sector changed middle-class aspirations and led doctors to be unsatisfied with public sector salaries. According to Baru, doctors began to care more for the self and less for society (Baru 2010, 91). The change in economic circumstances brought with it a perceived change in values: liberalization’s children are seen as consumers first and government servants second.

In 1964, India’s first Prime Minister Jawaharlal Nehru delivered a graduation speech at AIIMS that focused on social and preventive medicine, in which he worries about the number of villages that have no access to “modern” medical services. He acknowledges that India does not have enough medical colleges to meet the health care needs of the population (he would most likely be pleased at the number of doctors graduating per year by the time I write this), but urges those who do graduate with medical degrees to “always bear in mind the need of the people of India who live in the villages. Because they are in numbers as well as otherwise the real people of India and unless we know them, we do not function properly” (Singh 1988, 265). I will return to the idea of the village as “real” India in the following chapter. For now I am interested in Nehru’s acknowledgment of doctors’ reluctance to work in rural areas, even within this earlier generation. He continues:
I know that things are growing and medical colleges in India are producing more doctors. Even so, the rate is rather limited and most of them, I fear, prefer living in towns and cities and do not want to go to these odd villages, tribal areas, mountains etc. although I would have thought that the challenge of these areas, in mountains, in tribal areas, will appeal specially to men and women of enterprise and would draw them to them (Singh 1988, 265).

The neat division between the older, selfless generation and the younger, selfish one is complicated by Nehru’s focus on rural avoidance even in the Midnight’s Children generation, and on his perceived need to remind the new AIIMS graduates to keep the health of the rural population, and by extension the health of the nation, in mind.

Many of the doctors I asked perceived a generational difference between older and younger doctors, but not all saw generational differences in the same way, with some pushing back against popular portrayals of generational distinctions. Dr. Mohini, a young professor at MGMC, thought that “seniors [the older generation] were totally into their profession. They did nothing but work. They wanted to earn more and more money, and wanted as many patients as possible… Now we think we should be having a personal life. We are still unwilling to compromise on treating the patient, but we want a work-life balance.” For Dr. Mohini, senior doctors worked all the time – but in direct contradiction to the senior AIIMS doctors’ vision of themselves from Baru’s (2010) research, Dr. Mohini thought the older generation worked for the good of their own pocketbooks, not for the nation. Dr. Geeta, a resident at MGMC, surprised me by her readiness to indict her own generation. Dr. Geeta thought of her age group as the “lazy generation,” unwilling to work as hard as their parents. Dr. Sandhya, an intern at MGMC, concurred that her parents’ generation was more hard working: “they struggled really hard to become a doctor. Now we’re living easy lives, in cities. We’re getting enough pocket money, we’re spending it, we’re studying along with it. It goes easy.”
Somewhat less surprisingly, Dr. Bela, a senior doctor at a dispensary in urban Jaipur, found fault with the younger generation’s work ethic: “[the younger generation] are not so hardworking. If we give them some task, they will try to get out of doing it. This is happening in every subject, not just medicine.” Dr. Bela worried that the younger generation could easily get away with a lack of effort in the government sector. According to Dr. Bela, “in the private sector, [doctors] have to work hard. There it is all about money. Here in the government sector, you know what your salary will be and you can’t change it” – meaning that, no matter how little or how much you work, your compensation will be the same, thus there is no financial incentive for hard work. In the government sector, doing one’s job can mean, at a minimum, simply showing up once in a while. Results are less important than process – being in the examination room, filling out the paperwork, checking the boxes, filling quotas (George 2009, Gupta 2012). Beyond that, medical officers are free to construct their own ideals for what it means to be a good doctor.

In some ways working in the private sector demanded more of a doctor. Private sector doctors could be fired with no recourse. Unless the doctor was famous in their field, lending prestige to their hospital, doctors working in private hospitals were held accountable to their paying customers. This was less true for government doctors, according to an intern from MGMC:

JK: If a patient who goes to the government sector is upset for some reason with a doctor, doesn’t like the doctor’s behavior, is the patient able to complain?

Dr. Mohan (intern): I think there is a body for that, I don’t know that precisely, but usually that goes in the drop box. In the dustbin. Because, the government system here is like that only. Unless that patient has big political support, he belongs to a big political family. And you know, in such case the doctor himself already knows who he is dealing with. So he’ll make sure that he doesn’t lose his temperament over there.

Preference for work in the government vs. private sector, therefore, does not easily map onto generational differences. Those in the “lazy” generation have to weigh the benefits of government work (steady salary, fairly low expectations) with the reality that one’s first posting
is likely to be in a village, a place where, as I show in the next chapter, many in the younger generation had a hard time envisioning their lives.

Dr. Anandi, the young in-charge of Rajgarh CHC, had a different take on generational contrasts. She found older doctors to be stuck in their ways and unwilling to change, often to the detriment of their patients. When talking about improvements she wanted to make in her CHC, she said: “the old doctors don’t want to do that. They think that we can’t change everything, but we can change. Our generation can change anything. Yeah, we can change! If we want to change we can change, right? We are changing!” Dr. Anandi characterized herself and the other young doctors at her CHC as having a “positive attitude,” evident in her cheerleader-like advocacy for the possibility of improvements to the government sector. Her critique of the older generation was a general one, because in nearly the same breath she told me about her hero, the in-charge of Vijaynagar CHC, a senior doctor with a long career behind him. She told me that he had a similar vision for the transformation of his own clinic, working tirelessly to hold the CHC to a high standard. Thus, while the common story of generational conflict – older doctors were more dedicated, younger doctors prioritize their lifestyle over the health of the population – was certainly visible in some doctors’ narratives (and this story will return in other forms in the next chapter), exceptions and contradictions show that doctors were thinking about this in nuanced ways.

Is Medicine a Business or a Service?

I attended a presentation in one of the nicest classrooms at MGMC (with stadium seats and air conditioning) given by Health Oasis, an organization that helped Indian MBBS graduates apply to residency programs in the United States. Health Oasis offered opportunities previously
available only to students who knew someone in the US medical system, without whom the process could feel dauntingly foreign; now this kind of insider cultural knowledge was for sale. The presentation was intended to promote a four-week observership in American hospitals for MBBS graduates, arranged by Heath Oasis, to introduce Indians to the medical system in the US and to help them get coveted recommendation letters from American doctors to boost their applications to American residency programs. In attendance were mostly MBBS students with a few university dignitaries. The presenter, Dr. Punit, framed medicine primarily as a money-making enterprise:

It’s very important for you to understand that the career that you’re planning ahead of you is a business also in a sense. OK, we talk about taking care of patients, we talk about taking care of the society, but every doctor that graduates is an entrepreneur in themselves, and they are a business person…. You go through schooling, you go through college, you go through post-graduation, you invest a certain amount of money…. So you need to think, whatever career decision you make, what is the return on the investment that you make?

In Dr. Punit’s opinion, working in India with “just” an MBBS degree would not be an adequate return on investment. At the end of his presentation, MGMC’s president Dr. Punia stood up to address Dr. Punit in front of the now thinning crowd. “One thing that you have changed in the US is the concept of medical services. You say it is a business, but in our country, we consider it as a service to the society. So this is the difference.” He immediately amended his first statement with a faint air of defeat: “nowadays, in our country also, it is becoming a business…” Putting aside the fact that Dr. Punia was able to make his initial remarks without a hint of irony as the head of a medical college that just doubled its tuition, this interchange between Dr. Punit and Dr. Punia gets at the tensions I saw play out in doctors’ visions of their future. Dr. Punia occupies a position on the edge of this divide: he is himself an older doctor, raised in Nehruvian socialist ideals, but now works for one of the iconic signs of the burgeoning, money-mad private sector: the highly-priced medical college.
When health care is a commodity rather than a right, what does this do to health care services that are given freely, as many services are in the government sector? Rivkin-Fish (2011) explores this issue in the United States, where health care is so highly commoditized we cannot even come to a consensus that there should be a government sector offering health care to anyone. Rivkin-Fish follows dental students as they volunteer at a dental clinic for underserved populations. Here students come to understand “sets of assumptions … that define the kinds of claims they can make on each other and society at large” (Rivkin-Fish 2011, 187). Within the moral economy of Rivkin-Fish’s research, patients can only claim optimal treatment if they are willing – or able – to pay for it; when they cannot, they are failed consumers stripped of their right to quality dental care. Students are therefore surprised and angered when patients balk at the “gift” of getting multiple teeth pulled. In Rajasthan, the gift of health care in the government sector was a contested issue. I interviewed Assistant Medical Superintendent R. C. Gupta at MGMC just days after the 2014 national election, in which the right-wing Bharatiya Janata Party (BJP) and its leader Narendra Modi won via promises of rapid economic development. Dr. Gupta was optimistic about the changes Modi advertised, telling me that the new government would do away with “freebies” that discouraged people from working. He wanted to see fees for government health services. When health care is a commodity, it follows that people should not get it for free – they should work for it. Commodified health care opens up the possibility for doctors to feel like any care they provide is a gift to the population.

Dr. Anandi, the in-charge of Rajgarh CHC, envisioned a different result from the commodification of health care – she used advances in the private sector as inspiration for what the public sector might be able to achieve. She wanted her clinic to rival anything that could be found in the private sector:
Why do people like the private sector? They should come to the government sector. If we will [provide services] like a private hospital they will come to us. Why are they wasting their money in private hospital? We want patients to come and feel like we are also giving them the same thing.

Implicit in her statements is the criticism that government clinics are not as good as clinics in the private sector, even the CHC into which she has poured her energy, at least not yet. Dr. Anandi offers a gift to patients but it should not be of inferior quality because it comes for free; according to her logic the only difference between the government gift and the private sector commodity should be the price. Implicit in this argument is the somewhat radical idea that the government sector can be held to a much higher standard. Dr. Anandi stood out among the young doctors I interviewed in her unapologetic demand to improve standards for government sector primary care. But she was not alone in her belief that the government had the responsibility to provide services to the community.

Preventive and social medicine resident Dr. Kamlesh sat through about half of the Health Oasis event I described above before leaving. I asked him what he thought two days later while visiting with his family. Dr. Kamlesh told me that he found the whole thing strange because it framed medicine as just another way of making money. “Medicine is not a business! Medicine is a service,” he said, with no room for ambivalence. The preventive and social medicine department, with its emphasis on the social determinants of health, tended to sway the discussion towards the service end of things. This ideal was evident during the several interviews I conducted under the watchful eye of preventive and social medicine residents at the RTC. Methodologically speaking, I thought these were some of the worst interviews I had conducted – with their professor in the room, the atmosphere was stiflingly formal. But students knew exactly what they were expected to say in answer to my questions about doctors’ purpose and responsibilities. “To do community service.” “To do seva [service] for below-wale” [lower
socio-economic strata] people.” It was difficult to know how much these statements represented their own feelings and how much was a performance for their preventive and social medicine professor.

Neelam, the MBBS student who had dreamed of being a cardiologist, gave this issue a lot of thought. “Several people’s perspective is only income-based; several people think no, I will only do good; several people want to have a dignified manner. For me it is a compilation: I want to do good, I want an income, I want to live with dignity and at a certain standard. Because we are living in a society. We need to live like we have dignity, we have a standard, we have respectful honor from all the people we interact with.” Neelam speaks to a growing disconnect between the level of respect that doctors continue to receive and the government sector salaries that cannot compare with skyrocketing pay in the fields of business and engineering. Becoming a doctor earns respect, but also demands that the doctor live to a certain standard. As members of an elite profession, doctors will be asked to support their caste groups and communities in the form of time and money. Doctors are also expected to maintain a standard of living above the average. Medical students who, no matter their background, have already passed through the gates of an elite and exclusionary institution, feel entitled to a certain standard of living for themselves and their family, as well as a salary that would enable them to send their children to an institution like MGMC.

Diwan et al. (2013) wondered if they could detect a difference in the initial motivations of young people entering medical college in public vs. private institutions. They found personal ambition, parental choice, and the desire to perform service to the community to be about equally weighted among students’ responses. They did find a difference between students in government and private colleges in terms of their willingness to work in rural areas: government college
students expressed a greater willingness to work in a village, at least for the short term. Dr. Asha, a mid-career doctor in the government sector, echoes this sentiment:

In the US, I don’t mean to cause any offense, but money matters a lot. Here, at least in our generation, it doesn’t matter so much. …. We earn money only by relieving someone else’s pain. Medicine is a profession, it is a dedication, but it is not a business. If a person comes to my doorstep and he can’t pay, out of humanity I can give him money. I can’t give money to every single person who comes. But as a doctor, I can give my knowledge free of cost. I can write a prescription for him. It’s my duty. Eighty percent of doctors will say this. Unless maybe they have given huge fees to their medical college. Then they want to get something in return. But I have studied by the grace of the public. They say that the government is spending one lakh on each medical student. Our teachers said that the people pay taxes to fund our MBBS, so we have to give that one lakh back to the people. We used to be given that moral education from the first year.

The four MBBS students I interviewed at SMS all intended to enter the government sector. Ritu talked about being able to treat all kinds of patients in the government sector, while she could only treat “those who have money” in the private sector. Because my research at SMS was limited, I could not do a comparison between students’ views at SMS and MGMC. But it is interesting to note that many students at MGMC likewise wanted to enter the government sector despite the high fees they had paid. Of the twenty-two medical students at MGMC to whom I asked the question, only two were unequivocal about their desire to enter the private sector. Thirteen students preferred the government sector, one wished to join the army medical service, and the remaining seven were thus far undecided. Dr. Mohan, an intern at MGMC, will most likely join the private sector. He feels some responsibility to the community, but speaks of that responsibility in terms of treating his patients well and practicing medicine to a high standard, rather than sacrificing potential earnings in order to serve. As I was leaving the field, Dr. Mohan had started a job with a private NGO to make money while he continued to study for his PG exam. Tripti, an MBBS student, has a strong preference for the government sector, and not for entirely altruistic reasons. She mentioned the diversity and number of patients in a government
hospital that would allow her to quickly develop her skills, as well as the job security and pension offered by the government. Although none of the MBBS students I interviewed mentioned it, work in the government sector also offers the opportunity to make extra money on the side, as many government doctors also maintain a private practice in their off hours. Tripti was also swayed by the social capital conferred upon doctors, saying that government doctors “feel superior,” meaning that they feel like they are doing something good for the community and that they command respect.

Corruption and Critique

While working on this project I was repeatedly struck by conflicting portrayals of doctors in Indian culture. A medical degree confers status and honor upon its bearer, and individual doctors are often treated with reverence by their patients; at the same time, doctors and hospitals make frequent appearances in the popular media embroiled in scandal. It was difficult for me to assess actual instances of corruption among the doctors I studied, but the specter of corruption followed doctors everywhere. One doctor told me she thought eighty percent of doctors were corrupt and twenty percent were honest (a second doctor later came up with the same percentages). Another doctor told me he thought most doctors were ethical; I found out later that he had been arrested for illegal activity in his practice.

In 2010 Dr. Ketan Desai, the president of the Medical Council of India (MCI), was arrested for accepting bribes from a medical college in the state of Punjab. The MCI is supposed to ensure that the rapidly expanding number of private medical colleges in the country can provide high-quality medical training. Dr. Desai was forced to step down from his post, but rejoined the MCI as the state representative from Gujarat in 2013 – and now looks forward to a
term as the president of the World Medical Association, an organization tasked with setting standards for medical ethics across the globe. That such a high-profile figure could be accused of corruption and come out relatively unscathed is indicative of the extent of the problem. Doctors are accused of taking kickbacks for referring patients to diagnostic centers, taking bribes directly from patients, ordering unnecessary and costly tests and procedures, and illegally advertising their services (Khanna 2004, Ramayogaiah 2011). Corruption happens at all levels of health care, and judging by media reports, corruption among doctors is the rule rather than the exception.

A 2012 episode of the television show *Satyamev Jayate*, a popular progressive Hindi-language talk show created by Bollywood superstar-turned-activist Aamir Khan, profiles patients who have been injured or killed by unnecessary procedures at the hands of corrupt doctors. The episode argues that the system itself is corrupt and it takes an extraordinary doctor to stand up to it – and of course Khan finds several of these hero-doctors to come onto his show. To give an example: A doctor returned to India after doing a super-specialty in cancer abroad. He asked fellow doctors to refer their patients to him, and they responded that they would only do so if he gave them thirty to fifty percent of the patients’ fees as commission. He refused and found himself with no patients; he eventually left the country to practice in the UK. Another guest of the show posted a list of testing fees outside his diagnostic lab in the interest of transparency for patients. Doctors stopped sending him patients once he stopped paying kickbacks, but he suggests that patients are finding him anyway since he can charge dramatically lower fees than other labs. *Satyamev Jayate* illustrates the two archetypal positions that doctors inhabit in the public view: they either contribute to an impossibly corrupt system or they are bravely fighting it.
When corruption comes to light it is usually individual doctors who take the blame. A doctor responding to allegations of corruption in The Hindu, a prominent Indian newspaper, argues that it is impossible for doctors to earn money without participating in the system of financial kickbacks; therefore, doctors should not be the scapegoats for corruption in medicine (Gadde 2011). As she put it, “at the end of the day, we also wish to go home, spend quality time with our families, and mould [sic] our kids’ future. We didn’t sign up for sainthood” (Gadde 2011). This doctor pleads for a middle ground between hero and villain – a position where she can do her work and earn a living without making unreasonable sacrifices. The majority of doctors are neither better nor worse than the average person when it comes to questions of morality. In practicing medicine they want many things, including: an income, a comfortable life, a satisfying job, good education for their children, and the opportunity to help people. Sometimes they do things that we, looking from a position of distance, consider to be wrong. I was not able to address medical corruption head on in this project, but I do hope my research will show why doctors make certain choices that may not be in the best interest of the community they serve.

The aura of distrust that hovers around doctors in the Indian media is echoed in a social science agenda disillusioned with the institution of biomedicine and its practitioners. Known as the “medicalization critique,” this agenda was a dominant paradigm in medical anthropology and medical sociology from the 1960s to the 1980s (Lupton 1997). The critique was partially a response to sociologist Talcott Parsons’ functionalist interpretation of the role of doctors in North American society. According to Parsons, a sick patient is obliged to visit a doctor and then work to get well, while the doctor must motivate – or coerce, if necessary – the patient to improve (Parsons 1975:268). In Parson’s view, every person occupying a sick role is a person
failing to contribute to society; hence, the successful interaction between doctor and patient serves to make society run smoothly. The doctor’s role is therefore an important mechanism of social control. Parsons views inequality between doctor and patient with resignation, finding the power inherent in the doctor’s role to be necessary for the doctor-patient interaction to achieve its social function.

Proponents of the medicalization critique agreed with Parsons that medicine was a mechanism of social control, but worried over the implications of a powerful medical institution (Illich 1976, Freidson 1970, Zola 1972). Illich (1976) provides one of the most radical versions of this critique, in which the medical apparatus is a negative force *creating* rather than curing sickness and disease in order to control the population. People become dependent on drugs and high-tech solutions and lose the ability to take care of themselves; they consume health care even when they have no disease because they are trained to desire it (Illich 1976:33). For Illich, doctors are complicit in the medicalization of society, filling the role of priest offering salvation through medicine (Illich 1976:109). This is not far from the view of allopathic doctors that Gandhi espoused during the Indian nationalist period. For Gandhi, doctors helped to cause disease by offering an easy alternative to moral living: “I have indulged in vice, I contract a disease, a doctor cures me, the odds are that I shall repeat the vice. Had the doctor not intervened, nature would have done its work, and I would have acquired mastery over myself” (Gandhi 1994, 53). Gandhi’s argument falls apart quickly when one considers how well “mastery over the self” works to cure the diseases of poverty. Yet Gandhi’s moral critique still lingers in the national imagination (Visvanathan and Nandy 1997) – the image of the corrupt and immoral doctor exists alongside the image of doctor as healer.
Biomedicine has prevailed as the dominant medical system in India; although other systems continue to operate successfully alongside it, biomedicine is the default medium of governmental and non-governmental health care projects. The health of the nation is therefore, at least ideologically, placed in the hands of biomedical doctors, nurses, and health workers. At its inception, the rhetoric of India’s national health policy promoted health for all Indians as a matter of national pride. The doctor’s role, according to this rhetoric, was to work selflessly and heroically, putting the needs of patient and nation above his or her own (Jeffery 1978). Even as biomedicine increasingly becomes a privatized commodity, doctors continue to be held to this moral imperative. The resounding conclusion in both popular and scholarly media is that doctors, as a group, have failed to live up to their mandate.

The idea that doctors should work to improve the health of the nation does not always sit comfortably with the reality that doctors occupy an elite position in society. Freidson (1970) argues that doctors in the United States, by virtue of being medical “experts,” wield a great deal of power – they are able to define and treat illness and grant or deny access to the sick role. Sheikh and Porter (2011) draw on Freidson’s insights to examine the complexities of power specific to doctors in India. The high status of medicine as a profession combines with the usually high socio-economic and caste status of doctors to give doctors social and political capital. Sheikh and Porter argue that doctors have used their clout to create an insular profession protected from state regulation. Doctors in both the public and private sectors are able to ignore national health guidelines with few repercussions (Sheikh and Porter 2011). In other ways, however, their power is quite limited. Top-down public health directives do not offer space for doctors’ own experience and insight gained from engaging directly with patients (Sheikh and Porter 2011). Doctors have also failed to improve the working conditions in many government-
run clinical spaces, especially those in rural areas, where amenities provided for living and working can be sparse (Sheikh and Porter 2011).

**Governmentality**

After Foucault’s influence dramatically reconfigured the way scholars think about power, the medicalization critique lost some of its teeth. Doctors are no longer seen to “have” power; therefore power cannot be taken away from doctors and given to patients. Instead, biomedicine is seen as an institution capable of creating certain kinds of subjects: doctors and patients, as well as illness itself (Lupton 1997). For Foucault, this happens through regimes of biopower, the “numerous and diverse techniques for achieving the subjugation of bodies and the control of populations” (1990, 140; see also Rabinow and Rose 2006). Doctors are part of the diffuse workings of what Foucault (1991) called governmentality, a way of overseeing populations that encompasses three interconnected elements: 1) institutions such as the state and NGOs; 2) discourses and “common sense” knowledge and behaviors; and 3) the regulation of, and care for, the individual self (Ferguson and Gupta 2002, 989). It is fairly easy to see how doctors in the government sector are engaged with the overseeing of populations; they are agents of the state’s public health agenda. Doctors’ role as agents of the state became unusually clear one evening as I sat with Dr. Kavita during the night shift at a dispensary in urban Jaipur. Dr. Kavita held court in a room with a large table in the center surrounded by padded office chairs (for the doctor and visiting American researcher) and metal stools (for the patients). It had been a quiet evening, leaving Dr. Kavita lots of time to chat with me, when two policemen entered with four men in tow. The policemen sat the four down on a bench along the wall. Dr. Kavita pulled a book towards her with the word “Alcohol” handwritten in English on the cover. She regarded the four
men on the bench, then began to write reports in the book. After the policemen led the men away ten to fifteen minutes later, I asked:

"JK: So what happened with them?"

"Dr. K: With them? Actually they are all alcoholics, very bad alcoholics. Did you see their eyes were very flushed? They smelled? … If anyone drinks outside in a public place, the police will bring them here."

Doctors are responsible for writing a report to verify the policemen’s assertion that the men they bring in are indeed drunk. I asked Dr. Kavita how she decided this, since I only saw her look at the men from across the room. The men sat quietly on their bench, far from displaying disorderly conduct. She told me she bases it on a person’s smell, the look of their pupils, or on their speech. “Then if it seems necessary to us we do blood reporting.” Dr. Kavita did not seem to like this kind of work, which unfortunately made up a big part of the night shift. “Whomever a policeman brings in, we have to create a record…. We have to create it, so we do it. We don’t do it on our own [by our choice].” It seemed that Dr. Kavita was writing a report that would make the policemen happy and send them away, rather than seriously investigate the men’s level of intoxication. Dr. Kavita could not avoid being caught up in the policemen’s patrolling work – something far from the dreams of most medical students when they think about their future medical careers. Here Dr. Kavita is part of an institution that is actively disciplining certain bodies: those of men who drink alcohol outside, where they can be seen by the police. Dr. Kavita is ready to assume that the lower-class men brought in by the police are “very bad alcoholics” with little evidence, it seemed to me, beyond their being caught, signaling their lack of private, indoor space in which to drink.

Doctors are similarly entangled in the institutional response to sexual assault cases. All medical clinics and hospitals, whether public or private, must accept sexual assault victims and are required to conduct a forensic examination. Doctors have scant training in how to do this, and
much of what they learn has been proven to be ineffective at best and, at worst, emotionally and physically harmful (Agnes 2005, D’Souza 1998). One such spurious procedure is the “two-finger test,” where the doctor inserts fingers into a woman’s vagina to test for tightness and the presence of an intact hymen. This is meant to judge whether an unmarried woman is accustomed to sex and is therefore of questionable moral character – which of course has nothing to do with whether or not she was raped. In a study of medical textbooks used in India, Agnes (2005) found that “the presumptions are always against women, that women are prone to file false cases of rape…. It is little wonder that young doctors, who pass out from medical colleges fed on this doctrine, make unwarranted comments about the conduct and character of a rape victim, based on the level of elasticity of her vagina. The woman’s chastity, morality and virginity is put on the dock” (p. 1859-60). A journalist recently found that the two-finger test is still alive and well in the curriculum of a prominent medical college in south India, along with justifications for its use as a measure of sexual history before the rape ever happened (Ananya and Pillai 2014). Since the Delhi gang rape of college student Jyoti Singh in 2012, activists have pushed for reforms in all aspects of sexual assault response. In 2014 the government issued new guidelines for medical exams following sexual assault that begin with an assumption of the victim’s innocence and their need for protection. These guidelines emphasize the inadmissibility of the two-finger test as evidence. It remains to be seen what kind of impact the guidelines will have on medical exams and court cases.

Private sector doctors are also part of the reach of governmentality, even if they are not employed by the state, as they are similarly invested in shaping patients into appropriate consumers of biomedical services, and in providing services so patients can shape *themselves* into responsible subjects. Scholars have observed the reach of governmentality spread beyond
the state into international organizations as states themselves do less and less, passing their care
for the population onto private institutions, and this can certainly be seen in India (Baru and
Nundy 2008; Ferguson and Gupta 2002, Qadeer and Reddy 2006). MGMC is a good example:
the hospital receives benefits from the state, such as reduced taxes, in return for providing free
medical services to a segment of the population. Yet governmentality can also be found in a
small private practice with no ties to the government. Doctors and patients alike participate in
behaviors deemed by international public health organizations as well as the Indian state to bring
“health” to the population: in performing the rituals of check-ups, in vaccination campaigns, in
educating (or being educated) about appropriate hygiene behaviors, in the practices of
institutionalized births.

The third aspect of governmentality that I outlined above, care for the self, has taken a
starring role in public health (Lupton 1995). Neoliberal ideology, which emphasizes individual
rather than communal responsibility, allows health administrators to shift the burden of caring
for the population from the state to the people themselves. The state need only ensure that health
care is available in some form; actual “health” becomes the responsibility of individuals, who are
tasked with making the appropriate health care choices (Qadeer and Chakravarthi 2010). By way
of “techniques of the self,” then, individuals participate in government health agendas (Martin et
al. 1988; Rose 1995, 43). When patients mis-perform these techniques of the self, whether they
cannot for structural reasons or because they prefer not to engage with the biomedical agenda,
they are labeled as failed citizens. In the next chapter I show how patients’ failure to perform
biomedically prescribed behaviors maps onto rural space in doctors’ imaginations.

At Rajghar CHC, medical officer in-charge Dr. Anandi spoke about promoting education
and bringing in patients: “we are trying to educate them, counsel them, monitor them, so they
think, “they need us.” They don’t want to come themselves; we are calling them. That is the main mentality we are facing. Patients should think, “this is for our benefit.” They are not thinking that.” Dr. Anandi wants her patients to discipline themselves in the proper way, to come to the government clinic at the appropriate times, but they do not naturally perform these behaviors; Dr. Anandi must educate them before they can perform self-care in line with biomedical guidelines. For Dr. Anandi, education must begin even before the patient steps onto the threshold of her clinic. Dr. Anandi felt secure that her knowledge, biomedical knowledge, was the correct kind of knowledge. If only patients knew what they were supposed to do – in this case visit the doctor – and actually did it, the health of the community would improve. This is a message common to the global development apparatus: development will occur automatically through educating the population on appropriate, modern ways of living and behaving (Escobar 1995, Mankekar 1999, Pigg 1992).

Dr. Anita, a mid-career gynecologist who ran a private practice out of her home in a neighborhood of Jaipur with large, well-maintained single-family houses, told me her greatest responsibility was to spread awareness: to the patient, about what is beneficial and what is harmful during pregnancy, and to the patient’s family, about what she will need during pregnancy. Dr. Anita recently instituted free monthly clinics at her home to spread biomedical knowledge of childbirth. In addition to Dr. Anita, a male general practitioner and several lab techs were on hand in the courtyard to run free blood tests and answer health questions. Guests were treated to a small bag of oranges and bananas. During the several hours of my visit to the free clinic, two women patients walked past the tables set up in the courtyard and into Dr. Anita’s office, where she sat behind her desk to answer questions. One was experiencing menstrual problems while the other had pain throughout her body. The relaxed atmosphere of the
clinic (as well as the lack of other patients waiting) allowed Dr. Anita to sit with these patients for a long time – far longer than would be possible in most government sector settings. Dr. Anita welcomes any women to her free clinic, but she is especially eager to recruit pregnant women. She has prepared a prenatal educational program using a series of videos about what happens in each trimester of pregnancy and a book about labor and birth.

In my mind I had a dream, to run this type of project… for ladies who are pregnant for the first time. In their minds are many questions: what precautions should I take? What should I eat? What kind of medicines should I take?... They get answers to these questions from their family members and friends. So these people give their entire knowledge, and many times their knowledge is incorrect.

For Dr. Anita, lack of knowledge was the primary problem facing her patients – and the population in general: “suppose we make the mother aware, motivate her, then after [birth] the baby will be sick less. If the baby stays sick less, then naturally, the nation will get a good society, a good population.”

Dr. Anita must also work within the structure of the private sector, where the recruitment of patients and care towards growing one’s reputation are important aspects of her job. Dr. Anita is able to seamlessly blend service to the community with financial reward. She has developed her free clinic “to help the public. Because we can see that the public isn’t getting help now. So I hope that, from helping the public, my patients will increase.” With this turn of phrase, Dr. Anita links service with the growth of her practice – the more patients she gets, the more successful she will be – and the greater her positive impact on society will be. Dr. Anita advertises for her free clinic with flyers distributed through the surrounding neighborhoods; these tend to be women with plenty of money to pay Dr. Anita’s fees. For Dr. Anita, then, doing service does not require her patients to be poor; she wishes to educate her patients, whoever they might be (and however economically comfortable their situation).
Dr. Anita’s definition of service is important because it creates space for doctors to do good without attending to the most underserved patients in the population. While there are some doctors like Dr. Anandi who sacrifice their comfort, social life, and prestige to work in rural areas, medical graduates who are dedicated to the service of the population need not make such sacrifices. They can find urban work and still feel like they are making a difference. Dr. Anita is certainly helping her patients as she spends time talking through their questions and easing their fears. Medical students likewise feel that they are able to do service wherever they end up – whether private or public sector, urban or rural clinic – by attending to the patient who is in front of them, and by expanding the biomedical knowledge of the population.

Conclusion
In this chapter I have investigated the lead-up to the potential crisis medical graduates feel upon graduating with an MBBS degree, when the (unofficially) required PG exam looms, and a village posting to boost one’s chances in the exam becomes a critical choice. Unlike the students in Malawi’s medical college who experienced a clinical crisis that resulted in more “heart” for their patients (Wendland 2010), students at MGMC had yet to interact much with patients by the time of graduation. Career prospects that were slim in Malawi proliferated in Jaipur, particularly in the private sector. While many students were wary of a job in a large corporate hospital where they would work long hours with little job security, the private sector offered a path that bypassed the rural posting. Dr. Mohan had chosen this route as he worked for an NGO while studying for the PG exam.

Students and doctors were conflicted over whether medicine should be a money-making enterprise or a social service for the community. In contrast to the Malawian case, many had a
largely neoliberal, individualistic orientation to patients’ problems, explaining them by way of individual behaviors and a lack of education. Doctors thus framed their solutions in terms of educating their patients; this is how one could be a “good” doctor. An MBBS graduate could eschew nationalist-era meanings of service (working for marginalized or “below-wale” communities, particularly those who are medically underserved; living simply and dedicating one’s life to the people) to work in a corporate hospital and still see her work in terms of providing service to the community. If doctors were educating patients, they were doing seva, or service, and thus fulfilling their moral responsibility to the nation. Not all doctors slipped so easily into the neoliberal interpretation of service as education, yet this interpretation was there for doctors to fall back upon in explaining their careers, particularly if they found that, as women, they could not serve in a rural area. In the next two chapters, I turn my attention to the village posting. Working two years at a rural job offers medical graduates access to reserved seats in the following year’s PG exam; entering a residency unlocks all of the potential value in a medical degree. And yet, despite this considerable benefit, rural postings are a foreclosed possibility for many medical graduates, especially women.
**CHAPTER 4**  
RELUCTANT VILLAGERS

*Introduction*

A professor at MGMC who never seemed to see any worth in my research there advised me that what I *really* should have done was visit a village clinic – that was how I could see the “real” India. We were (unwittingly, on my part) replaying an exchange between Gandhi and a group of foreigners, in which Gandhi told them that “if they wanted to ‘see the heart of India,’ they should ‘ignore big cities,’” venturing at least thirty miles from the railway line into the interior of the country (Jodhka 2002, 3347). As an anthropologist-in-training with Malinowskian visions of proper anthropological fieldwork “out there” dancing through my head, I headed into the Rajasthani countryside. When I returned to the medical college a few days later, the professor could not hide her surprise that I had actually left the city. In her opinion, the village may be “real India,” but it is not a space for educated urbanites and foreigners. Nor does rural India hold much attraction for doctors. As I elicited stories of the village from doctors, interesting paradoxes emerged about what the village signified and what the doctor’s place in it should be.

The village manages to be simultaneously the heart of India and Indian culture but also a place embarrassingly in need of transformative development. Because the rural is seen as a space of backwardness and a place yet-to-be developed, most young doctors had a difficult time imagining their lives there. The village is so far removed from the typical urbanite’s experience that it now exists as a theme park: Chokhi Dhani, a fake village just over two kilometers from MGMC, offers a “perfect Rajasthani experience” for middle-class urbanite pleasure seekers.

For Rs. 700 (around $10), diners can eat on the floor in tents, watch dancers, snake charmers,
and puppet shows, and try their hand at archery. The “authentic” village has been neatly commodified for national and international tourists and Jaipur residents.

For the majority of Rajasthani doctors, “village” and “city” were salient categories to be compared and contrasted, resisted or embraced. Doctors often referred to rural India as the “interior” whose polar opposite was the “metropole,” or large city. Because the city was seen as the center of medical activity, a doctor’s trip from city to village was described, paradoxically, as “going out into the interior” of the country. There was some discrepancy among doctors regarding what exactly counted as the interior. The state defines rural areas based on data such as population density and the percentage of people working in agriculture. People who lived and worked in villages unsurprisingly had a much more nuanced idea about what constituted the interior, as well as the “interior interior” – meaning the real middle of nowhere. Those in villages along the highway to Jaipur told me that this was not the “real” interior since it could be reached so easily from the city. Yet the same professor who urged me to go out into the “real India,” looking at things from the perspective of the city, thought that these easy-access villages were indeed the real thing, or at least real enough to induce surprise over my visit there.

In this chapter I call upon narratives of the rural in order to contextualize the shortage of village doctors in Rajasthan. North American and British anthropologists working in India during the mid twentieth century looked to villages in order to understand Indian culture and “civilization;” they would most likely agree with the medical college professor that “real” India could be found in a village (Marriott 1955). At the same time, these anthropologists did not find a unitary village, instead documenting diverse spaces (with some common threads) (Marriott 1955, Srinivas 1960). Since then, anthropologists have further argued that there is no such thing as the village; villages are diverse spaces forever in flux (Cohn 1987, Jodhka 2016,
And yet, in doctors’ narratives, the multiplicity of rural spaces overlapped and coalesced into an imagined village, an image that circulated in medical spaces and informed young doctors’ decisions about where and how they might live. This imagined village did more work for those students who had little real-world experience of village life; those who had rural ties were able to offer counterpoints to the standard narrative I encountered in the medical college. Yet even the students with rural backgrounds could not escape the hierarchy of prestige that placed cities above villages, or the timescale that framed villages as backwards spaces. The city and the countryside were inseparable in doctors’ narratives – each existed only in relation to the other (Massey 1994, Williams 1973).

Doctors’ stories tended to weave around four sometimes contradictory themes. First is the idea of the village as the “heart” of India, a concept of the village that can be traced back to nationalist period rhetoric, when leaders debated how India could industrialize while still retaining some essence of “Indianness.” Second is the idea of the village as empty space. Rural India, of course, houses the majority of the country’s population – it is full of people and activity. But for doctors, villages are empty of what really matters when it comes to building a satisfying career and a full life. Third, doctors describe villages as backward places inhabited by backward people. This creates a danger to the doctor-as-outsider whose biomedical ideas clash with those of their patients. Finally, villages are seen as threatening to middle-class, urban women. When thinking about women’s safety, suddenly the formerly empty village fills up with the wrong kind of men (lower-class, under-educated) who pose a threat to the middle-class woman’s bodily integrity and propriety (I explore this fourth theme in detail in the following chapter). I argue that, seen together, these stories of village life create an urban medical image of
the rural landscape – an image that has practical consequences for the provision of rural health care when it keeps women doctors away from rural work.

Following Rodman (2003), my research shows that “places come into being through praxis, not just through narratives” (p. 207). Doctors talked about the village from the space of the city, and they also took decisive action when it came to rural clinical sites: they accepted a village posting and made it work, or they refused a village posting. Refusal of the interior is not just a decision affecting the doctor and the health care opportunities of the village; these decisions further shape the interior as a place that is not hospitable for women doctors. Women doctors are made to not belong in the interior through stories circulated back to the cities, through lived experiences, and through refusals to occupy village space. In addition, place was important to doctors’ project of differentiation between themselves, as subjects who have secured their place in the middle class, and subaltern middle-class aspirants (Bhatt et al. 2010, Fernandes and Heller 2006). In village narratives, doctors used the village as code for low educational and class status – and by separating themselves from the geographical space of the village, they also put metaphorical distance between themselves and their subaltern Other.

**Contested Views of the Village**

In this section I consider three prominent nationalists’ competing conceptions of the village: M. K. Gandhi, Jawaharlal Nehru, and B. R. Ambedkar. Nationalist imaginings of the village were complicated and contested. For these Indian statesman the village was, respectively, a place of authenticity, a place of backwardness, and a place of oppression (Jodhka 2002). These three understandings of the village are all still in circulation today, albeit coexisting in a context dramatically transformed from that of India’s independence in the mid twentieth century.
Gandhi first conceived of the village as a way to contrast “authentic” Indian life with foreign, Western influence: the “village was the site of authenticity, the ‘real/pure India,’ a place that, at least in its design, had not yet been corrupted by the western influence. The city was its opposite, totally western” (Jodhka 2002, 3446). According to this logic, cities were sites of the degradation of true Indian culture rather than sites of progress. Gandhi also placed the village at the center of his political vision for de-colonization. He proposed a government based on panchayat raj with de-centralized control, “posing the Indian village as the direct counterpoint to the modern imperial state” (Mantena 2012, 537). Mantena (2012) argues that Gandhi’s vision was more complicated than a desire to return to a pre-colonial vision of the village. “Rather, figuring the village as a site of autonomy represented a critical reconstruction and radicalization of the imperial discourse on the apolitical and static nature of Indian society” (Mantena 2012, 537; emphasis in original). In other words, Gandhi may have reached into the past to claim romanticized visions of the village, but he used these to construct a very new kind of political organization that put the village front and center. The village was thus crucial to Gandhi’s vision for a new, yet still authentic, Indian society.

Jawaharlal Nehru, a prominent nationalist who became India’s first prime minister, had a different relationship to the village, and a different vision for India’s future, than that of Gandhi. Instead of looking to the past for authenticity, Nehru looked to technology and land redistribution, with urban-rural linkages, to bring India’s villagers into the future. The village became a “backward” place in need of development, both in terms of industrialization and in the need to move beyond the caste system, which in Nehru’s words had “degraded a mass of human beings and gave them no opportunities to get out of that condition – educationally, culturally, or economically” (Nehru 1946, 254; quoted in Jodhka 2002, 3348). Nehru’s view of the village was
an evolutionist/modernist one, in which industrialization, agricultural reform, and social restructuring were necessary to move India forward.

Finally, B. R. Ambedkar offered a scathing critique of Gandi’s understanding of the village as representative of “authentic” India, as well as Gandhi’s fundamental acceptance of the caste system. Ambedkar was a Dalit activist during the independence movement and, as India’s first law minister, wrote much of the nation’s constitution. Ambedkar saw the village as a space organized to oppress Dalits, who were ghettoized outside village boundaries (Jodhka 2012, 3350). If the village was the symbolic “heart” of India, then, Dalits found themselves outside the scope of India altogether. Ambedkar opposed politicians who wanted to make the village the basic political unit of Indian society, arguing that this move upholds the current hierarchy to the detriment of Dalits:

This is the village republic of which the Hindus are so proud. What is the position of the untouchables in this Republic? They are not merely the last but are also the least… in this Republic there is no place for democracy. There is no room for equality… The Indian village is a very negation of Republic. The republic is an Empire of the Hindus over the untouchables (Moon 1989, 25-26; quoted in Jodhka 2012, 3351).

Cities, on the other hand, provided potential anonymity and reinvention that a village’s close social world, where everyone knew everyone else, did not allow. Statues of Ambedkar have spread through cities and villages, particularly in the state of Uttar Pradesh where India’s first Dalit Chief Minister, Mayawati, was elected in the 1990s, bringing with her state support for Dalit symbols (Jaoul 2006). Violence and desecration of the statues have also spread as non-Dalits take offense to the symbolic assertion of Dalit rights in the public sphere.

In front of Jaipur’s private medical college, however, it is Gandhi who holds court, while behind him rises MGMC’s shining testament to medical technology. Today, Gandhi’s statue looks like he belongs in a village in his homespun dhoti. Gandhi’s statue is out of place and out
of time at MGMC, perhaps imagined as a symbol of India’s tradition that could anchor MGMC in morality, a good public relations move considering the moral suspicion with which new private medical colleges are viewed in India. In her analysis of 1990s-era Bollywood films (those my medical student interlocutors grew up with), Sharpe (2005) shows how villages began to evoke both a different space (not-city) and a different time (an imagined past) as film settings became increasingly urbanized and globalized. When rural spaces appear in these films, they are “emptied of the culture of everyday life,” existing “not as a geographical location so much as a signifier for a simpler way of life prior to globalization” (Sharpe 2005:60).

Figure 4: Mahatma Gandhi Hospital
The Empty Village

Jocelyn: What would you miss most about the city?

Dr. Sandhya, intern: Malls! [laughing]

By the time of my research Rajasthani cities, buoyed by the neoliberalization of the health care sector, had enthusiastically welcomed the kind of technology required by advanced biomedical practice. This technology was not, however, flowing to villages. Therefore the specifically medical vision of the village is first and foremost one of technological lack – an underdeveloped and non-industrialized space where the proper practice of medicine cannot take place. This idea is beautifully illustrated in the Hindi film Ek Doctor ki Maut (“A Doctor’s Death”) released in 1990, near the beginning of the sweeping changes that would overtake India’s economy. The title character is a doctor doing research in a large urban hospital who upsets his supervisor and, as punishment, is sent to a coastal village. The film’s title refers to the doctor’s symbolic death; in the far-off space of the village he can no longer carry on what he feels to be crucial work. A doctor, according to this film, is someone who advances knowledge, not someone who cares for the everyday complaints of the majority of India’s population. Unfortunately for the doctors who find themselves providing primary care – and for their patients – working as a medical officer in rural government service entails precisely the kind of work scorned in this film, and in the medical profession more generally. The village thus becomes a place for failed medical careers and for failed consumers of advanced medical technology.

After hearing doctors’ narratives of the village in Rajasthan, I began to imagine what a biomedical landscape in Rajasthan might look like, envisioning urban hubs of activity surrounded by negative space. Medicine happens in cities, while negative space is created in the interior in large part by the practice of doctors avoiding it (Munn 2003). Pigg (1992) describes
the landscape of Nepal similarly: “the overall impression is of islands of not-village surrounded by a sea of villageness;” the village becomes everything that is not the city. This is precisely how villages are defined by the state in India: urban spaces have particular definitional criteria, while rural spaces are simply everything left over (Bhagat 2005). This separation implicitly declares the city to be the important pole in the city-village binary. For doctors too, the village is defined as not-city; the biomedical gaze simply cannot see spaces without technologically equipped hospitals or the trappings of urban middle class life. And yet, the negative space of the village is constantly haunting the young medical graduate who must cross the hurdle of village work in order to reap the benefits of a government job.

Most obviously, villages lacked material things like paved roads and reliable electricity. In terms of medical work, rural spaces lacked the tools and technology required to practice all but the most basic form of medicine. PHCs are often small concrete structures with no steady water supply, no working toilet, and few comforts for doctor or patient. The lack of supplies in most PHCs keep them operating as triage units rather than treatment centers. The one thing doctors can do in rural Rajasthan is to distribute free basic drugs provided by the state. In Krishnapura PHC, boxes of drugs stacked high filled half the room, dwarfing the other sparse furnishings (a patient bed covered with dusty piles of paperwork, a desk, and a small metal stool to distinguish the patient being examined from the line of those waiting). But even the plethora of drugs provided by the state does not always satisfy doctors. Many complained that the drugs are cheaply made and do not work as well as their commercially-available counterparts used in the private sector. CHCs provide more facilities than PHCs do, but it does not follow that they are always in tip-top shape. Dr. Bindu has worked in a CHC in Dausa district for the past fifteen years. When I asked her to tell me something about her hospital, she launched into a long list of
complaints. “There is no maintenance of instruments, no labor table, things are not properly washed.Soap isn’t available for hand washing, can you believe it? I bring soap from my home to the hospital.” The material lack of tools and supplies required doctors in rural hospitals to practice an entirely different method of medicine compared to the urban teaching hospitals where they had learned their craft. Every time I went to see Dr. Roopa, a dentist who had been posted at Vijaynagar CHC for six months, I found her texting on her phone or chatting with the other two women doctors at the clinic. When dental patients came, she could prescribe painkillers but do little else – she had yet to receive any dental tools from the government. By coming to sit in her office every day she was doing her job as defined by the government and was able to collect a paycheck. Without any tools, however, her skills lay wasted.

Moving to a village impacted a doctor’s way of life far beyond the hours spent at the clinic. Doctors found it difficult to imagine how they would continue to perform their social status as urban middle-class professionals from the space of the village. Simply bringing a middle-class bureaucrat’s salary to the village does not mean that a middle-class life of the type doctors expect is possible there; class is, of course, about far more than financial hierarchy (Bourdieu 1984). Mankekar’s (1999) study of lower-middle-class television viewers in Delhi found that people maintained their fragile middle-class status largely through access to consumer goods, newly available and newly advertised between their favorite TV shows. Liechty (2003) argues that aspirants to the middle class in Kathmandu, Nepal require “cultural strategies, systems of prestige (“status”), and forms of “capital” that are not, strictly speaking, economic” (p. 15). In Delhi and Kathmandu, then, the performance of middle-class-ness demands a set of behaviors that are largely linked to the consumption of “modern” goods such as televisions, refrigerators, and fashion. This performance involves a material economy and a moral economy;
modern consumption, done within set boundaries, makes one respectable and therefore able to claim middle-class status (Liechty 2003). Moreover, Liechty suggests that young people are integral to middle class formation: “class, consumption, media, and youth must be seen as not merely interactive but mutually constitutive cultural processes” (p. 6, emphasis in original; see also Lukose 2009).

In Jaipur, young medical graduates are helping to shape what is an acceptable life for middle-class doctors. As I argued in Chapter 3, doctors are expected to make a comfortable salary and to have earned, through their medical degree, a safe position in the middle class.59 Doctors in all stages of their careers told me how the experience of a middle-class life had changed. Dr. Bela, who graduated from medical college in 1977, has worked in the government sector for most of her career. She reminisced about the differences between her childhood and her daughter’s (her only child). Dr. Bela was one of five children, who all had to get out of the house in the morning with only one bathroom:

I just went out like this [pulling her hands through her hair] and combed my hair once I got to school. Also we only had two or three dresses – we didn’t have so much. Now my daughter has a full wardrobe, and she’s always concerned about what she should wear.

Young doctors have so much more than their parents’ generation did, and they could certainly survive with less. But actually choosing to survive with less, opting out of the appropriate kinds of consumption and thereby sacrificing one’s class position, is a radical choice. The lifestyle a doctor is expected to maintain has changed and doctors must keep up.

If doctors merely needed access to consumer goods of the type described by Mankekar (1999) and Liechty (2003), their middle class life could be transported to the village with minimal difficulty. People in villages hold middle-class aspirations, and they have their fair share of refrigerators, televisions, and smart phones. All manner of consumer goods can be brought to
the village and used for at least part of the day when the electricity is flowing. Instead, I found
that many of the new kinds of consumption available in Jaipur were simply not possible outside
the city, particularly in terms of the *process* of consumption rather than the use of consumer
goods like TVs. When not chatting on each other’s beds in the hostel, medical students spent
their free time going out to restaurants, malls, multiplex cinemas, and coffee shops. McGuire
(2011) argues that bodily dispositions, created through the process of consumption, help to mark
some bodies as middle-class and others as not. McGuire observed people cultivating these bodily
dispositions in New Delhi malls, which, it seems, have been designed for shoppers on different
levels to peer up or down at each other: “it is important that one is *seen* consuming, and that one
can *watch* others consume” (2011, 128). Bodies thus gain middle-class status in part through the
gaze of other urban middle-class consumers. None of these modern, sanitized public/private
spaces occupied by doctors’ peers are available in the interior – as MGMC intern Dr. Sandhya –
whom I quoted at the beginning of this section – says, she would miss malls the most.

These spaces are especially important for middle-class women, as they allow women to
spend time with their peers outside of the home or hostel. Phadke (2007) argues that the presence
of women in malls and coffee shops is “a marker of the modernity of the city and its claim to
global status;” modernity requires the visible presence of women in these spaces outside the
home (p. 1514). Medical students explained to me that Jaipur was not a “metro” like Delhi or
Mumbai; nonetheless, these kinds of modern spaces were ubiquitous across Jaipur’s urban
landscape. Furthermore, the designation of Jaipur as a modern, global place to live hinged on the
presence of these spaces; it follows, then, that villages without such spaces cannot be proper
residences for doctors aspiring to a modern lifestyle.
One afternoon I draped myself in a good sari and took an auto rickshaw to Dr. Rashmi’s house in Jaipur to attend my first “kitty party,” a common social event for middle-class women. As usual I was the first one there after trying, and failing, to calculate the actual start time based on the time I had been told to come. I sat on the couch and chatted with Dr. Rashmi’s sister as Dr. Rashmi flitted around getting ready. Middle-aged women began to stream in and soon we were down to business. The proceedings began with a game of housie (bingo) with cash prizes for the winners. Then I watched the women masterfully slurp pani puri, wafer-thin globes of pastry filled with green vegetable-flavored water. This was followed by ice cream. Finally the women took out their wallets to deliver fat wads of bills into the “kitty,” a financial pool that was given out to a different member each month. The festivities and food were the frills decorating a rotational savings program that was only possible among women of similar socio-economic standing. But saving was not the only reason for the kitty party’s existence. Waldrop (2011) argues that kitty parties in New Delhi allowed middle-class housewives to forge female friendships and gain exposure to other people and ideas. While doctors may have far more opportunities than housewives for “exposure” to the world through their work, they still seek socially approved avenues for friendship with their peers. This is a kind of social interaction that doctors did not feel they could find in a rural setting, populated with women who they imagined to be very different from themselves.

For most doctors, the village was empty of their peers. Dr. Nandini, a young unmarried doctor who commutes daily from her parents’ home in Jaipur to her clinic in Krishnapura village (approximately two hours by bus), said one of the reasons she avoided living in the village was that “the way of living is mashed up here.” This means, Dr. Nandini explained, that doctors need a social circle for their mental health; they need “a place to sit in the evening” – meaning not just
a comfortable place to rest one’s weary body, but a space filled with the right kind of people to talk to and pass time with. The village was, for her, a job that she did while she waited for something better; it was not a way of life. Wrapped up in the potential loneliness of a village life was the fact that Dr. Nandini could not engage in the behaviors – such as meeting her friends at the mall and hosting kitty parties for other women – that maintained her class status. Finding a social network would not be as difficult for doctors working in a CHC, which employed several doctors who could form a close social group. Vijaynagar CHC employed three women doctors whom I usually found sitting together outside the obstetrics ward on the second floor. One was an obstetrician, one a medical officer, and one was Dr. Roopa, the dentist with no tools. Although she could only perform a shadow of her job, Dr. Roopa had other women of her social class to help her pass the time. Young doctors working in the smaller and more solitary PHCs felt that there were not any other people in the village who were at their social and educational level.

Dr. Asha, a mid-career doctor who had spent time in two different villages, told a story to describe the wildness and desolation of village space, inhabited by animals rather than people:

"It is so hard for lady doctors to live in remote areas. If the clinic is one or two kilometers away from a village, how can the doctor live there alone? There is one [PHC] in Kotputli that is in the forest and a panther lives nearby. One time it was found in the [living] quarters. A panther!

Dr. Asha had only heard of this panther, but the story performs work in separating acceptable urban spaces from wild rural ones. Doctors do not have to worry about finding wild animals in urban hospitals (beyond the usual insects, pigeons, and stray monkeys, none of which invoke panther-level fear). Moreover, Dr. Asha felt that spending time in the village had changed her. “You can’t find people who have similar thoughts to you. You spend time with village people and you become jangli [wild or uncivilized] within six months! After I had been living in [a
That the village had made Dr. Asha “jangli” made sense to me; it is a short rhetorical trip from “backward” to “uncivilized.” Her use of “tribal” was more curious, as tribal usually refers to a caste designation, a tenacious human trait that is not subject to change merely by moving from city to village. The overlap between “tribal” and “uncivilized” does have a long history in India, beginning with colonial-era evolutionary theory separating “primitive” tribal groups, commonly called Adivasis, from (relatively) more “civilized” “caste” Hindus and other groups belonging to named religious traditions: Islam, Jainism, Sikhism, etc. Indian nationalists perpetuated this distinction between “wild” and “civilized” groups, until “the idea that Adivasis… were primitive became deeply entrenched in the perceptions of dominant Indian groups” (Skaria 1997, 741). Nationalists further contrasted the sexuality of Adivasi (and often low-caste or low-class) women, seen as promiscuous, uncontrolled, and immodestly dressed, with that of middle-class Hindu women, seen as chaste wives and mothers (Ciotti 2010, Skaria 1997, Unnithan-Kumar 1997). For Dr. Asha, “tribal” does not map onto an idea of sexual promiscuity, but rather refers to the inability to fit into the modern cityscape. She explained that after becoming “tribal,” she now feels shocked at seeing women wearing short skirts and sleeveless tops when she visits Delhi. She also described becoming afraid of taking the bus and moving around in the city after spending a long time living in a village. “Civilized” women, on Dr. Asha’s scale from tribal to civilized, have no trouble showing their arms and legs or traveling freely on buses – they are relatively more free from the constraints of modest dress and limited movement. Dr. Asha’s discourse of “jangliness” performs boundarymaking work, distinguishing between city and village, as it shows how the village can transform a person in undesirable ways. Villages emerge therefore not merely as spaces, but as constellations of thought and behavior (in this case, undesirable thought
and behavior). Dr. Asha implies that traveling freely in a city and gazing without judgment on a woman’s bare arms are positive, desirable actions; and yet, her time in the village has left her unable to do them.

I stayed in Vijaynagar village with Prema, an elementary school teacher at an English medium school. Prema and her husband could be considered part of the aspirational rural middle class; both worked professional jobs, although they had few of the consumer goods described by Mankekar (1999) aside from a refrigerator. Their house had intermittent electricity and water was delivered twice a day, whether or not they needed it, and stored in a large stone tank in the living room. Prema had no access to the kind of public/private spaces inhabited by urban medical students. There was no space in the village for her, or for me, to “hang out” outside of the domestic realm of courtyards and kitchens. When Prema walked in the streets of the village, she covered her head and face with her ghunghat, the free-flowing end of her sari. She had been raised in the southern state of Maharashtra where she found the rules for women to be much looser. When she visited her natal family she saw couples outside socializing in the evenings. In Vijaynagar, married men and women did not socialize together even at home (casual conversation was nearly impossible in the presence of her husband’s male relatives, in front of whom she had to cover her face). She chatted with other women next door in their courtyard, or with her sisters-in-law in their newly built house a short (ghunghat-covered) walk across the fields. Prema took the bus to Jaipur one day to meet me for a shopping spree, and I was surprised to see her wearing a sari with her head uncovered. She reveled in the anonymity of the city. We headed to the bazaars of the old city for bargains rather than the shiny malls where medical students and doctors often shopped, which proved to be far beyond the budget of a village schoolteacher. She bought two pairs of jeans and a few T-shirts for her upcoming visit home. We
laughed at the shopkeeper’s shock when Prema asked for jeans in her own size – what would a married woman in an inexpensive polyester sari, signaling her distinctly non-jeans-wearing social position, be doing dressing like a middle-class urban teenager? Prema’s experiences illustrate the different kind of rules that govern social life in lower- and lower-middle-class spaces, which doctors attributed to rural spaces as well. Doctors, as high status outsiders to the village, were in many ways exempted from the rules that governed local women’s behavior. But the differences in doctors’ dress and modesty practices served to further isolate doctors from the social life of the village.

These stories illustrate the overlapping fields of class and place. Doctors cannot perform a proper middle-class lifestyle from the space of the village. Even if one could import modern conveniences into the village, it is impossible for doctors to be modern, middle-class consumers, as they have envisioned this position, in the space of the village. Doctors may be concerned with the health of the rural population in theory, but sacrificing their well being and their class position for such an abstract concept does not sit well with most young doctors. If a position in the middle class is something constantly in process, doctors cannot simply reach it and then stop. To move to the village is to take a step back, to move backwards in space and time. Indeed, as I explore in the next section, “backwards” is a term applied often to the village and the people within it.
The Backward Village

*People are a little rough in the village. If something goes wrong there will be trouble. Rural life is dangerous for a doctor.* – Dr. Nisha, resident in OB/GYN, Ratna Hospital

Recognizing that city-village dichotomies are always fluid (Ferguson 1997, Massey 1994), my snapshot of spatial discourse in Rajasthan represents a particular moment. The village doctor in the popular imagination, if s/he ever actually existed, was at the time of my research a nostalgic throwback to an earlier era when doctors lived simple lives, unhindered by the compulsion to consume. Along with the village doctor, villages themselves are imagined to exist in a particular space and a particular time; this timescape also aids in the production of a village Other in comparison to the urban, modern doctor (Escobar 1995, Fabian 1983, Massey 1994). This image of the village and the people who reside within it allows doctors to declare the village backward on a technological timescale that stretches from the pre-colonial to the contemporary period.

Following the pattern of speaking about villages in terms of material lack – of supplies, electricity, and technology – there was also a consensus among young doctors that the people who lived in villages were somehow lacking: they were uneducated, “backwards,” deficient in social skills, prone to violence. The discourse of backwardness came up again and again in my interactions with doctors, emerging so readily that it seemed well practiced. Nehru’s modernist framework is visible in both the “empty” village and the “backward” village, wherein the underdeveloped village, populated by undereducated people, is differentiated from the industrialized city inhabited by modern, knowledgeable people.

Doctors used the discourse of backwardness to account for a wide variety of behaviors they encountered in the village. For example, many doctors felt that the rural population did not understand the limits of biomedical treatment and would blame the doctor if a patient dies, often
Doctors do face a very real threat of violence from the community in Rajasthan. During my year of fieldwork, several accounts of doctors being attacked by patients’ relatives turned up in the local media. This does not happen only in rural areas; in fact, the most high-profile case of violence that year happened to several doctors at a tertiary hospital in the city of Bikaner, precipitating strikes at urban hospitals across the state. But, because young doctors tended to associate violent retaliation with a lack of formal education, and a lack of education with villagers, they were more suspicious of the rural population. Several doctors made a distinction between the educational levels of urban and rural patients living in poverty, declaring urban patients to be savvier when it came to health and biomedical treatment. Violent retaliation proved to be a battleground between doctors and the government. Doctors continued to call for greater protection from the public, which they felt to be the responsibility of the government to provide. In large teaching hospitals this could translate into added security – for which an infrastructure already existed to facilitate crowd control. In rural clinics, and especially in small PHCs, added security personnel were simply not an option. The state health care administration could not reach into every corner of Rajasthan to protect its doctors. Doctors therefore depended on their relationship with the local government and the village community to have their back, with highly variable results.

Dr. Kavita, a medical officer who had recently been transferred to Jaipur city, was full of stories about her years spent in rural clinics. Her first posting after finishing her MBBS was in a PHC in Jhunjhunu district. When I asked her if she encountered any problems with local residents, she replied “Not at all! The people were very good; they were very simple. Meaning they thought that whoever is the doctor, if she will help us, and if she comes on time, she won’t be bothered.” And yet, “sometimes, rarely, some small thing happens in every place.” She
elaborated with a story: “one time it happened that a patient came,” an elderly man who insisted that Dr. Kavita give him a glucose drip because he was feeling sluggish. She refused, deeming his request to be medically unnecessary. After some time he returned to the clinic with a group of men and a padlock.

I was in the hospital, and he said he would lock me in. Two or three other notorious people came with him. They live in the village and don’t do any work. They said, ‘we’re locking you in because you don’t listen to any of us here. We asked for a drip but Madam refused.’ So I said fine, put the lock on – you are the ones who will be in trouble with the police. Then the people who came with him, who knew more than he did, they understood. They apologized.

In this case, villagers threatened Dr. Kavita over the rather innocuous matter of an IV. This kind of story, in turn, strikes fear into the hearts of young doctors without rural experience – how might the situation escalate if the dispute is over the death of a patient rather than a simple IV?

Dr. Kavita’s response to this incident shows the confidence of a doctor who knows she has the local police on her side. She enjoyed her posting at the PHC in Jhunjhunu largely because she felt comfortable in the community there. Not incidentally, her in-laws lived in the same district, the importance of which I explore further in the next chapter. Things unfolded differently for Dr. Kavita when she was transferred to another posting at a CHC in Dausa district. When I asked her about the transfer, the first thing she mentioned was a caste-based conflict stirring in that region of Dausa for several years. Gujjar caste members were vying for reservation status as an OBC group and the protests often turned violent (other OBC groups were against Gujjar inclusion). Dr. Kavita described the region as a “quite notorious area” populated by “rude” people. Dr. Kavita was from a caste group with OBC status in Rajasthan but without political clout in the area of her CHC. Her position as an outsider meant that she could not count on community support for her work and life in the village. Of seven doctors at the CHC she was the only woman and was required to handle all of the women’s reproductive health duties of the
The male doctors said that “deliveries are totally your responsibility.” So I had a lot of problems. Sometimes it happened that I didn’t have time for eating. I would eat 2-minute Maggi [packaged noodles]!... So I became very lean – more lean than I am now [laughing]. There was a lot of work there. And I didn’t like the people there.

Her complaints went nowhere. One evening a group of people brought a sixteen-year-old girl to the CHC who, according to Dr. Kavita, had already died from electrocution by the time she reached the clinic. Dr. Kavita explained to them that nothing more could be done for her. The girl’s family accused Dr. Kavita of negligence – they argued that the girl was still alive when they arrived and Dr. Kavita had refused to save her. The girl’s relatives, who were politically connected in the village, were able to bring Dr. Kavita’s supervisor onto their side. Dr. Kavita explained that she was saved from being transferred out of the village by a group of pharmaceutical suppliers whose shops faced the CHC:

They can tell all of the stories about the hospital – who comes, when they come, how it happens, who works, who doesn’t work. They told the in-charge [head doctor], “this Madam does a lot of work; we have seen that you are causing her problems night and day. And a lady doctor has come to our area after a long time. If you cause her to be transferred from here, we will never leave you alone.” Meaning, they took my side.

Dr. Kavita makes a clear distinction, as many doctors do, between “political people” who use their power to manipulate the medical system for their benefit, and honorable people who have the community’s best interests at heart. But it is difficult to separate these two designations from the caste politics that overlay them. For Dr. Kavita, “notorious” people belong to a particular caste. Likewise, when Dr. Asha, who belongs to an upper-caste group, talks about becoming “tribal” from living in a particular village, she draws on the assumed confluence of caste and character – the calling upon the “tribal” designation to explain her increased conservatism cannot
be separated from the official caste designation that marks some groups as tribes, even when their members may live in cities, work as doctors, and wear sleeveless shirts. While no doctor explicitly labeled a caste group as backward, the implications are clear in their language when villages are simultaneously associated with particular caste groups and deemed less cosmopolitan, or less educated, or prone to violence.

Dr. Divya was working on a postgraduate degree in preventive and social medicine when I met her; she had also cultivated a private practice out of her home in urban Jaipur. When she first graduated from medical college, she was posted in an isolated area of Bharatpur district. She lasted only eight days at the clinic before returning home to her family in Jaipur. She was one of the first women I interviewed who had rural experience and I was eager to find out the whole story. Dr. Divya, on the other hand, had no intention of telling me. She asserted several times that the village was a “disturbed place” not suitable for women doctors: “a male can sustain there but a female cannot.” She was unwilling to say anything more about what had happened to her there. Months later, she was willing to talk to me about why villages are risky for doctor-outsiders, but only in general terms:

If some incident happens, no one will step up to help you. This is not because they are bad people – there are both good and bad people in the village. But they can’t speak out against the panchayat [village council], against the neta [leader], against whoever has done wrong to the doctor. They are part of their community; the doctor is the outsider. They have to continue living here; the doctor can leave.

Dr. Divya’s experience highlights the plight of women doctors as outsiders in the village. For Dr. Divya, the village is empty of social support and risky enough that she chose to leave after a week, opting out of the government sector altogether.
Disrupted Motherhood

A problem of village work that came up again and again in women’s stories was the issue of disrupted motherhood. The first time I met Dr. Anandi, the in-charge at Rajghar CHC, she was very enthusiastic about her job. She had big ambitions for the CHC – she felt she could attract more patients by modeling her clinic on the private sector. She was concerned with patient satisfaction and wanted patients to choose to come to her hospital, not just come out of necessity because there was nothing else. She had accepted a three-year rural contract, but had enjoyed her work so much she stayed on for an extra year. She was in the midst of this fourth year when I met her. When I saw Dr. Anandi again at the end of my research period, she confided in me that she was thinking of moving to Australia. I was taken by surprise – in my mind, Dr. Anandi was a rural success story. Her success had also come out of a unique situation: she was married, but her husband was working abroad and only came home for short breaks. She lived alone in her rooms at the clinic (but was not entirely alone; she had good relationships with other doctors also living in the hospital quarters, including one woman). The problem, Dr. Anandi explained, was that she was tired of living apart from her four-year-old son. Because she lived by herself in the village and worked long hours, Dr. Anandi had sent her son to live with her in-laws in Jaipur. She had a car and could easily go to visit him on the weekends, but this was not enough. She felt that she had been asked to make a major sacrifice for the sake of rural health care: “We have sacrificed our normal female life. I have a son, but I’m not with him.” She explained with heavy emotion in her voice how her son dreads her leaving on Monday morning to return to the village: “He’s scared every time: ‘I know it mama, when I go to school you will leave!’ That time I feel, you know, I feel like crying.”
Dr. Meenakshi, the in-charge at Devipura CHC in Dausa district, has lived apart from her son since he was eight months old. At first he went to stay with her parents in Jaipur district. At age eleven he began living in Jaipur city with a maid; this remained his living arrangement at age sixteen. Dr. Meenakshi feels that this is the only way for her son to be properly educated. When I asked if her son was able to visit during school vacations, she told me that he never comes to the village. Dr. Meenakshi first explained that he does coaching during school vacations and could not afford to miss it. But other reasons emerged: her son has “requirements” that cannot be met in the village. He likes eating fast food, he feels uncomfortable in the heat, his computer wouldn’t work. It seemed to me that Dr. Meenakshi and her son indeed lived separate lives, and that life in the village could not adequately prepare him for a professional career in the modern world. I was surprised, then, when she told me that her son wanted to become a doctor. Dr. Meenakshi wishes that her son will eventually follow in her footsteps: “I hope he does something for people’s health. Our entire family is dedicated to the service of poor people.”

The family arrangements of women doctors may provide a space for the disruption of patriarchal, patrilocal norms that require the mother to be primary caregiver. Lack of childcare options did not emerge as a significant problem for most women doctors. But being absolved of childcare responsibilities did not create a feminist paradise for doctors – the women I met in this situation were not happy about it precisely because it required living apart from their children. Dr. Sapna, who works with Dr. Meenakshi in Devipura, has sent her two children to live with her parents in another district capital. “I don’t like it! I have no time to watch them. My first duty is as a mother, but I have no time for it. Friday is my day off; I go to Alwar to see them. My husband [a doctor in the same clinic] goes on Tuesday, his day off.” I did not meet a single rural doctor whose children went to school in a village. From what I have seen, separation from one’s
school-age children is a mandatory component of rural work for doctors. Even if doctors have rural roots, they must send their children to live in a city if they want them to gain competitive educational credentials.

Both men and women experienced emotional distress from this forced separation, but women face the additional burden of being responsible for their children’s nurturing and education. In Rajasthan the mother was held up as the best person to raise and educate a child. Donner (2008) similarly found that middle-class stay-at-home mothers in West Bengal spent much of their day structuring their children’s studying, and that fathers had become “less involved in the education of their children than their own fathers had been” (p. 133). It is not easy for working women to compete with stay-at-home mothers’ participation in school-related tasks. But women living separately from their children must relinquish control over much of the day-to-day work of educating their children, broadly defined (and in the competitive educational environment of India this is no small task). And yet, women doctors working in villages chose living separately again and again: urban education won out over maternal oversight of children’s day-to-day lives. Mothers did not like this sacrifice but chose to make it nonetheless.

After I had returned home from the field, an MBBS student from MGMC shared a Hindi language advertisement for Ariel laundry detergent on her Facebook page. The advertisement, entitled “Share the Load,” is filmed from the perspective of a woman’s father. The father watches as his daughter comes home from her job outside the home in a flurry of activity, making work arrangements on her phone while she serves tea to her husband (he watches TV on the couch for the duration of the video). Still on the phone, the woman begins cooking dinner, puts her child’s toys away, and starts the family’s laundry. The woman’s father, observing all of this, narrates, apologizing on behalf of all fathers who have set a bad example for their sons by
avoiding domestic and childcare duties. The advertisement ends with the father returning to his own home, determined to help his wife more around the house. “I may not be king of the kitchen, but at least I can help with the laundry,” he says. This advertisement stood out, and went viral, because of its unusual critique of men’s avoidance of domestic work. Advertising images targeting middle class and elite women over the last decade have foregrounded, and valorized, women’s position as wives and mothers even as they showed women to be “modern” and cosmopolitan. As Oza (2006) found in her study of these advertisements, “the ubiquitous figure of the new woman was nowhere more apparent than in advertisements for domestic appliances such as microwaves, washing machines, detergents, etc…. In each of these instances, the persistent narrative was that the primary responsibility of a woman was to maintain the home” (p. 33). For doctors, domestic work such as cooking and laundry was less fraught than the issue of motherhood. Many doctors employed servants for such tasks (although occasionally extended-family households chose not to hire servants, creating a higher burden of work for their doctor daughters-in-law). But motherhood was seen to be a different category of domestic work, not so easily delegated to others. Women who work in villages thus face the choice between being good doctors and good mothers; they have “sacrificed [their] normal female life” for their careers. Passing one’s children to the care of someone else signaled a kind of failure of motherhood.

\textit{Rural Ties}

Thus far I have made a distinction between “rural” patient and “urban” doctor, where doctors may live within village confines but are not seen to be \textit{of} the village. While most of the doctors I met were raised and educated in urban settings, I did meet some who complicated the separation between urban and rural. I introduced Dr. Shireen in the last chapter, the self-described “poorest
person in my class” at MGMC. Dr. Shireen grew up in a remote village where she was the first woman to have any education beyond ninth grade. A group of doctors from her caste group raised money to pay for her tuition at MGMC on the understanding that she would return to her home village to practice medicine for the local women.

Dr. Shireen: The people who have helped me to do my studies have made a big sacrifice, so I want to help them. In our society girls don’t study. I’ll be the first girl doctor in my district, from my community.

JK: If it’s possible, do you want to return to your home area?

Dr. Shireen: Yes, if my husband is ready to go there, I want to go back. I want to build a small hospital there. Where poor people, families below the poverty line, can go to get free treatment, wherever possible, or can get treatment for less money. I don’t have a desire to earn money. I just want to help people, however many people I can. That’s my idea.

Dr. Shireen should be an ideal candidate to work in a rural clinic, yet even she was unsure about her long-term plans. She worried a great deal about finding a husband who was willing to live in rural Rajasthan. She had already rejected a potential match suggested by her father because the boy’s thinking “wasn’t like mine.” The boy asked her: “why do you want to be Mother Teresa? You should live your life, you should take your own enjoyment. Why do you want to trouble yourself with helping others?” Ideally, Dr. Shireen wants to find a husband who is a doctor, is of her caste group, from her area, and has similar altruistic career goals. In practice this is turning out to be a tall order – but necessary in order to allow her to remain in the village long term. To complicate matters further, Dr. Shireen took a job at a prestigious hospital in Delhi immediately following graduation. Even though Dr. Shireen is of rural Rajasthan, her growing credentials mark her as an outsider. Dr. Shireen’s very success stands in the way of her original goals.
The Positive Village

While the general consensus among doctors was that cities offered them the best prospects for lifestyle and career, there were some exceptions to this rule. Dr. Kanta lives in a small city in Jaipur district with her parents. When I met her she was preparing to get married to a young man who was also a doctor. She worked as a medical officer in Rajgarh PHC within commuting distance of her parents’ home. Dr. Kanta told me she felt entirely comfortable working in a village. “Right now it’s totally simple! No problems! It’s totally good, I’m free.” For Dr. Kanta, Rajgarh was not a “village of strangers;” it was merely a short (less than twenty kilometer) ride away by bus or jeep from her home place, which itself was practically a village when compared to Jaipur’s bustling population of three million. I did not get to know Dr. Kanta as well as I would have liked, either in our initial interview (she was a deft interviewer herself and kept turning the tables on me) or in my subsequent visits to Rajgarh when she was on leave celebrating her marriage. She knew that she had it easy as an unmarried doctor working so close to home, admitting that her present “freedom” came from being single: “after marriage I don’t know what will happen,” she said, laughing. Dr. Kanta’s spirit was hardly dampened by the supposed deprivations of rural work, at least on the day we talked. Another doctor at Rajgarh, Dr. Sonali, did not share Dr. Kanta’s easy acceptance of rural work, yet still preferred it to being in a large city. Dr. Sonali lived in the clinic’s quarters with her doctor husband and infant son. She had completed an MD in pediatrics but was working as a medical officer, biding her time until the government was able to match her, and her husband, with specialist posts. Dr. Sonali was unhappy at Rajgarh, not because it was a village, but because she was not able to use her specialist skills. In fact, she preferred to be outside of a metropolitan city:

JK: In five years, would you still like to be in a rural hospital, or in a big city? Or somewhere in between?
Sonali: In between. Never in a city like Jaipur.

JK: Why not?

Sonali: Because I have always belonged to cities which are smaller. And the life is easier. [And you can] serve the people who are unreached. The areas around Jaipur, even Rajgarh, here there is an oversaturation of doctors.

For Dr. Sonali, metropolitan cities provoked far more anxiety than rural areas did. She was willing to move even deeper into the interior as long as she could work as a pediatrician – and her husband could be posted nearby.

Along with Dr. Sonali, several other doctors mentioned serving the rural population as a motivating factor in choosing rural work or in rationalizing their position as rural medical officers despite the accompanying lack of prestige. Most doctors would rather have the respect that comes from working a specialized job in an urban hospital, but those who end up in rural areas are able to call upon a different type of social capital by helping those most in need. There were few doctors I met who did not mention the goal of helping people. I asked Dr. Anju, a mid-career doctor who had worked in the same rural PHC for many years, what she liked about working in a village. She replied, “I like working for humanity. They don’t understand much, and I can explain it to them.” Like the “real” India I mentioned previously, Dr. Anju’s concept of “humanity” exists in the village. She gains social capital by helping humanity and by separating herself from it. Moreover, Dr. Anju is not selflessly forgoing the comforts and attractions of the city in order to serve the rural population. Her clinic is just past the boundaries of Jaipur city, and she maintains a house in Jaipur that she can reach easily by car.

Dr. Varsha works for the Rajasthani government as a public health administrator with an office in Jaipur. At the start of her career she worked in a village for eleven years alongside her husband. There are many things about rural living that she now looks back upon fondly. She explained:
It is comfortable to work in a rural area. People there have trust in you. The people all come from the local area, and you get to know them – the same people will come to you again and again. People have respect for you. In the city, a patient comes to me one day, then the next day goes to another doctor, then the next day goes to a third. People in cities have faith in the institution but not the individual doctor.

For those who are able to adapt to life in the village, then, there is something potentially to be gained. Dr. Varsha also misses the time she was able to spend with her children in the village, where her schedule gave her more free time. She eventually moved to Jaipur for her children’s education, but in some ways she regrets it:

In the city you probably live away from the hospital – you don’t reside on campus. There will be a thirty to forty minute drive. You sit in the hospital from eight to twelve, then you go home. You cook food, you wash clothes, you organize things. Then you go back to the hospital for the afternoon shift. By the time you get home around eight at night, you have no time for your children. This is the biggest compromise. You want to give quality time to your children but you’re exhausted. You want to be able to help them study. We came to the city thinking our children would get the best education. But the thing we were giving in the rural area is missing here.

I asked Dr. Varsha if her children’s generation would ever be willing to work in a rural area. She replied, “if we told them to go there, they’d say ‘where is McDonalds? Where is Pizza Hut?’ It would be difficult for them to go now and get adjusted.”

I began this chapter with a Hindi film, *Ek Doctor Ki Maut*, where the doctor-hero of the film experiences the village as punishment. Another more recent film, *Swades* (2004) approaches the village in a different way. The film begins in the United States, its hero Mohan (played by Bollywood star Shah Rukh Khan) working for NASA. Mohan travels to India hoping to bring his childhood nanny, the only person left in his family, back to the US with him. He must live in the nanny’s village while awaiting her decision. Fearing how he would adjust to village life, Mohan brought with him a technologically-advanced mobile home filled with bottled water. Mohan’s habitus, like that of urban-raised doctors, keeps him from belonging in the space of the village.
While Mohan’s difficulty with village life is played for laughs at the beginning of the film, slowly Mohan does adjust, and as the film ends Mohan has committed to apply his engineering knowledge to the development of the village (he literally enlightens the village by providing them with electricity). The message of the film is clear: highly-educated Indians have a responsibility to their homeland, and the homeland (at least symbolically) is rural India. While Bollywood blockbusters certainly do not reflect real life, they do show aspirations and cultural values. Dwyer (2010) argues that Hindi cinema, more than other media, “is one of the most productive arenas for us to discern clearer patterns of India’s social imaginaries, so we can learn how India sees itself today, how it hopes to see itself in the future, and how it views its past” (p. 384). Mohan stands in for a generation of urban-raised, educated Indians who recognize rural India as a place in need of development. Medical students and doctors likewise articulated rural India’s need to escape backwardness: to move forward, to develop. Yet to be the hero, to actually do the developing while immersing oneself in the space of backwardness, is no easy feat.

**Conclusion**

If the village is a place of strangers, or a place of backwardness, or a place where modern medicine barely exists, it takes a certain kind of moral work to overcome these barriers and choose to work in the village (or rationalize one’s involuntary existence there). Even for someone like Dr. Shireen, who is from a village and who entered the medical profession in order to return to a rural area, social realities threaten to steer her in a different direction. The paradoxical phrase that I mentioned above, “going out into the interior,” brings to light doctors’ unusual relationship to the village. The village has long been seen as the heart of the nation, whether one looks at cultural metaphors or actual population numbers. For doctors, however, the
village is clearly the periphery – a very large periphery that surrounds urban islands where the real business of medicine gets done. The village may be a symbol of the “real” India, but for urban-raised doctors, it is a land far different from the India they know, a foreign land posing sometimes insurmountable challenges to their lives and careers. The two understandings of rural space that I have highlighted in this chapter, the empty village and the backward village, have profoundly gendered implications. Space that is empty of the right kind of people, and that is instead filled with a population deemed backward, becomes threatening particularly to women. In the next chapter I explore the risk that follows women doctors to the village.
CHAPTER 5
RISK AND PROTECTIONISM IN THE VILLAGE OF STRANGERS

Introduction

Dr. Nisha, an OB/GYN resident at a private hospital in Jaipur, had worked as a rural medical officer for six months after finishing her MBBS. After she told me that rural work was dangerous for doctors, I was curious to hear about her experiences.

JK: Can you think of any specific example? Was there a time when something went wrong and the villagers blamed you?
Dr. Nisha: [Long pause….] Uh, no I can’t remember any specific thing.
JK: But you just remember that you felt it wasn’t safe.
Dr. Nisha: Yes.

Dr. Nisha went on to explain that rural work was more dangerous for women than for men, although again she could not offer any specific examples. For Dr. Nisha, rural spaces simply were unsafe. This feeling of general unease permeated my research. Dr. Nisha’s colleague, also a PG student in OB/GYN, gave strikingly similar answers to my questions about her own previous rural posting.

JK: Did you face security problems in the village?
Dr. Madhu: Yes! Especially in the evening time, or during festival times, people there are alcoholics. The village is not safe for women during these times.
JK: Did you experience any problems personally?
Dr. Madhu: No, no, but still it was not safe.
JK: Do you know anyone who experienced problems?
Dr. Madhu: No.

Here the narrative of risk and danger shows its power, where doctors continue to view the village as a risky space even when their own experiences show them otherwise.\(^65\)
In the previous chapter I began to explore narratives of the village that mark it as unappealing and dangerous for doctors. Here I focus on one aspect of this danger, the threat to women’s sexual purity, that is the subject of much public anxiety and debate. Most of the public discussions about women’s safety and sexual violence focus on middle-class urban women’s right to occupy the space of the city. I argue that the risk intensifies when these women leave the city, the dangers of which are mapped and known, to enter the relatively uncharted territory of the interior. The discourse of risk was so powerful that many women doctors continued to view the space of the unknown village as a threat to their safety and well-being even if they had experienced villages without facing trouble. The threat proved remarkably persistent, in part because of its vague and diffuse nature – it was difficult for doctors to pin down exactly where the danger lay, and therefore difficult to mitigate that danger short of simply refusing to occupy certain spaces. In this chapter I analyze the social construction of feminine risk, looking at theories of danger and “risk society,” and at feminist conceptions of gendered space. I then link this discourse of risk to the ways in which it disciplines female bodies, requiring that women consider potential risks to their sexual purity and bodily autonomy as they move through space.

**Women’s Mobility in Rajasthan and the Nation**

I begin with a discussion of very basic mobility to show that women’s mobility is an issue that the Indian government recognizes and tracks through data collection. The most recent National Family Health Survey published by the Government of India (2017)\(^6\) includes data on women’s ability to travel unaccompanied. The survey asked women if they could go, alone, to three specified places: a market, a healthcare facility, and outside of the village or community (see Table 8). In Rajasthan, fewer than half of women could travel to these three places alone, except
for two subgroups of women: 1) women over forty-nine years old; and 2) women who have
twelve or more years of formal education. The percentages for India as a whole are slightly
higher than those for Rajasthan and include a great deal of internal diversity: there were states
where less than twenty-five percent of women had this basic mobility, and states where over
eighty percent of women affirmed that they could visit these three places.67 This data shows that
women’s mobility even within their neighborhood cannot be taken for granted in parts of India.

<table>
<thead>
<tr>
<th>Percentage of women able to go unaccompanied to all three of the following places:</th>
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<tr>
<td>1. A market</td>
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<td>2. A healthcare facility</td>
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<td>3. Outside of the village or community</td>
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<th>Age</th>
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<td>5-9 years</td>
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<td>10-11 years</td>
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<td>12 or more years</td>
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<tr>
<th>Number of children</th>
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<tr>
<td>No children</td>
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<td>3-4</td>
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<td>5+</td>
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Table 8: Women’s Basic Mobility in Rajasthan and Nationally (Source: GOI 2017).

Women’s mobility increases with age, a finding Lamb (2000) explored in her study of aging in
the state of West Bengal. What struck me from this data is that women’s mobility decreases as
women collect years of schooling, then increases dramatically when women reach twelve or
more years of school. Doctors, who have attended far more than twelve years of schooling, can easily scale this low bar for basic mobility. The National Family Health Survey groups mobility with other signs of women’s “empowerment” such as control over money and household decisions, ability to negotiate safe sex, and ownership of a mobile phone (GOI 2017). Doctors, as already-empowered career women, are assumed to have no trouble with mobility. I show in this chapter that, particularly regarding relocation to rural spaces, women doctors do find their movements restricted.

The issue of women’s mobility has caused anxiety in India for generations. Chatterjee (1993) argues that women’s mobility outside the home was reconfigured during the nationalist period. According to Chatterjee, mobility was contingent upon women performing a particular type of femininity, one that allowed them to escape purdah and move through the public sphere, but nonetheless required a woman to stress “the spirituality of her character:”

Once the essential femininity of women was fixed in terms of certain culturally visible spiritual qualities, they could go to schools, travel in public conveyances, watch public entertainment programs, and in time even take up employment outside the home. But the “spiritual” signs of her femininity were now clearly marked – in her dress, her eating habits, her social demeanor, her religiosity (Chatterjee 1993, 130).

Chatterjee’s argument positions women as the guardians of Indian tradition in the realm of the home, allowing their husbands and sons to work outside in the Westernized public sphere. Women could only venture outside if they were able to protect this traditional Indian virtue as they went. The sexual purity of women’s bodies, therefore, is linked to the nation as well as to the family. This linkage helps to explain more recent anxieties from Hindu fundamentalist groups about women’s modesty and purity. Menon (2010) shows how members of this movement rhetorically place women into the non-sexualized role of mother of the nation. Women in the Hindu right are symbols of honor within the Hindu community (and by extension,
the imagined Hindu nation), but women’s ability to access this honor is contingent upon “how self-sacrificing they are, how well they suppress their own desires to serve the needs of their husbands and children, and how carefully they protect their own moral integrity” (Menon 2010, 167). In this framework, women who step outside of these roles – appearing sexualized, or seeking any kind of pleasure for themselves – become objects of critique. This Hindu nationalist morality also leads to victim-blaming in the wake of sexual violence. In 2013, Mohan Bhagwat, leader of the Hindu nationalist organization Rashtriya Swayamsevak Sangh (RSS), had this to say about rape, which simultaneously blames women and positions cities as immoral, Westernized spaces: “rapes take place in cities and not villages. Women should refrain from venturing out with men other than their relatives. Such incidents happen due to the influence of Western culture and women wearing less clothes” (Dhillon 2017). Babulal Gaur, home minister of Madhya Pradesh state and member of the Hindu nationalist BJP party, said that women in the city of Chennai (in the state of Tamil Nadu) were safer than women in his own state because, in Chennai, “people are religious and women visit temples every day. They are fully dressed and there is no vulgarity” (Vincent 2014). While this understanding of women’s purity might be most pronounced coming from the Hindu right, it can be found across conservative-leaning elements of the political spectrum. Abu Azmi, a politician from the secular Samajwadi Party, responded to a question about the rising number of rapes with the warning that “women should not venture out with men who are not relatives,” echoing the statement of RSS leader Mohan Bhagwat above (Dhillon 2017). These politicians feel secure enough in the popularity of their beliefs to continue to express them despite outcry among feminists and in much of the press.
The Discourse of Risk

I argue that the concept of sexual purity, and the need for women to protect it, leads to calculations of risk: how risky might a village posting be to a woman’s bodily integrity and sexual purity? As Dr. Nisha’s and Dr. Madhu’s statements from the beginning of the chapter show, village postings are deemed dangerous not necessarily because of women’s direct experiences of danger (although some women doctors certainly have experienced threats to their safety), but because of a vague threat of danger. It is important to consider risk as a cultural product rather than something “natural” out in the world waiting to be discovered (Douglas and Wildavsky 1982, Harthorn and Oaks 2003). While there are countless potential dangers to bodily integrity and honor, some are chosen by society while others are not; therefore “what needs to be explained is how people agree to ignore most of the potential dangers that surround them and interact so as to concentrate only on selected aspects” (Douglas and Wildavsky 1982, 9).

Douglas (1994) distinguishes between danger, which entails an imminent threat to the body or self, and risk, which is a way of thinking about danger. Risk, for Douglas, it is a calculation of potential dangers, often involving experts and the creation of statistical knowledge. Castel (1991) similarly differentiates between danger and risk: “the notion of risk is made autonomous from that of danger. A risk does not arise from the presence of particular precise danger embodied in a concrete individual or group. It is the effect of a combination of abstract factors which render more or less probable the occurrence of undesirable modes of behavior” (p. 287, emphasis in original). Castel, who uses the example of psychiatric patients in France, sees a historic shift from a focus on danger or conflict, such as the act of causing someone harm, to a focus on the risk that a particular person is likely to harm someone in the future.  

This shift allows certain people to be labeled a risk to society even in the absence of evidence of individual dangerous
behavior. In India, as I will show in this chapter, a particular population of men – lower class and rural – is deemed risky to middle-class women, justifying the need for paternalistic protection. The rhetorical move from danger to risk is an important one. It allows Dr. Nisha and Dr. Madhu, with no personal experience of danger in the village, to continue to assert the dangers of a village posting. In their eyes, rural space was risky because they felt the presence of risk even if no danger materialized during their tenure there.

During the winter of 2012, a young woman named Jyoti Singh and her male companion were attacked on a private bus in Delhi while returning from an evening movie. The men on the bus sexually assaulted Jyoti Singh with a metal implement; she later died from her injuries. This incident sparked mass outrage because of who this woman was (a college student, upper-caste and aspiring to the middle class), where it happened (in a cosmopolitan city), and the brutality of the crime. College students, including medical students, protested throughout the country to demand greater safety for middle-class women in urban public space. This incident brought the issue of women’s safety in public space, particularly urban, to the forefront of national discussion. Sexual assault was not new to media headlines; women have a long history of protesting sexual violence in India (Kumar 1993). Many of the brutal rapes and murders that make it into the press involve women from marginalized communities and men who assume the ability to harm them with relative impunity. The incident in 2012 brought a different possibility, with a new spectrum of anxieties, into the national spotlight – that relatively low-status men could attack an upwardly mobile college student. The 2012 rape caused anxiety for middle-class women in general, and medical students in particular – they could see themselves in the victim.

Phadke (2007) argues that safety in public spaces stems largely from the level of claim one can make to that space: “It is more than the promise of not being physically harmed, it
includes the knowledge that should one be harmed one’s presence will not be looked at askance” (Phadke 2007, 1511). Phadke’s analysis of risk centers on middle-class, upper-caste, heterosexual women in Mumbai, who ostensibly should be most able to stake a claim to the space of the city – these are privileged women who live in what is deemed the most “women-friendly” of Indian cities. It is the presence of these very women, traveling to office buildings, shopping in malls, and sitting in cafes, that marks a city as modern. Yet Phadke found that even these women could not claim a legitimate right to be outside of domestic space. Like Jyoti Singh, they were blamed for anything that went wrong: Why was she out after dark? Why wasn’t she traveling with a relative? What was she wearing? The response to feminine risk tends to be one of protectionism that restricts women’s movements outside of the domestic sphere and requires them to manufacture respectability. A deeper look into this form of protectionism shows that women’s purity, rather than their bodily safety, is the main object of rules restricting women’s mobility (Kapur 2014, Niranjana and Vasudevan 2016, Phadke 2007, Puri 1999). The politicians I quoted above are quick to attach shame to the victims of sexual assault. They imply that a woman’s character is, at least in part, to blame – “good” women do not dress suggestively or venture out with non-related men. They are more concerned about the woman’s respectability (or lack thereof) than they are about her physical safety. Phadke (2007) found that women in Mumbai would sometimes engage in behaviors that put their physical safety at risk in order to ensure their respectability; for example, when a young woman asked her boyfriend to drop her off outside of her neighborhood late at night, forcing her to walk alone, so that no one would see them together. Phadke concludes thus:

The curious thing about respectability is that it begins to assume a value that supersedes safety – that is, from the perspective of communities and families, the preservation of women’s respectability and honour implicitly outweighs the value placed on actual safety…. The problem with valuing sexual safety over other
kinds of safety is that when safety for women becomes exclusively sexual safety, it assumes the form of surveillance (2007,1512).

If women’s safety were truly the object of protectionism, public discussion of risk might instead turn inwards into the home or neighborhood, the sites where the majority of violence against women take place (Niranjana and Vasudevan 2016, Puri 1999). And yet, the discourse of risk focuses on spaces where family protection cannot reach. As Phadke mentions above, the outcome of this concern with women’s reputations is greater surveillance of women’s movements, tracking where they go and with whom they interact. Strategies of surveillance meant to keep women safe are entangled with strategies that prevent women from engaging in the wrong kind of relationships with the wrong kind of men; in essence, constraining women’s ability to have sexual encounters outside of heterosexual marriage, whether those encounters be invasive or welcomed.

In a study of women call center workers in Mumbai, Patel (2010) analyses the “mobility-morality” narrative that shapes women’s movement through space. Women working the night shift in the tech industry must travel through the city at times when “respectable” women are supposed to be at home; therefore, women outside at night must go to great lengths to perform respectability. According to Patel, a woman’s choice of attire (in addition to other displays of respectable middle-class femininity) “comes from remaining aware of how patriarchal regimes of surveillance perceive her bodily existence – whore versus homemaker – and reflects how far some men believe they have a right to go – from unwanted gazes to rape – when they consume a woman’s body” (Patel 2010:61). Women traveling in Jaipur worked to cultivate a homemaker image (through signs of marriage such as the mangalsutra worn around the neck) or a “homely” daughter image (through demure dressing and purposeful movement between home and school).
Women who fail to perform homeliness risk association with its only alternative, the whore, opening them up to potential blame for any unwanted attention or even violence.

Because tech work is fairly new, it makes sense that the women in Patel’s study face confusion about their activities and their unusual working times. In contrast to call-center work, the practice of medicine is a well-established career for women in India. Nevertheless the ordinariness of medicine as a career for women does not translate into greater leeway for escaping the whore/homemaker dichotomy. When I asked doctors why medicine was seen as such an appropriate career for women, many told me that it offered them an opportunity to work within the space of their homes (doctors have the option of opening a private practice that overlaps with domestic space, but this is difficult for young, not-yet-established doctors to pull off). If the home is the source of a woman’s respectability, it follows that traveling away from the home increases the need for women to outwardly perform their respectability. Many doctors saw the village as being impossibly far from their home – both in measured kilometers and in symbolic distance. They tended to speak about this distance in terms of danger rather than respectability, but the two are inseparable in the discourse of risk that frames respectability as the antidote to risk.

In the previous chapter I considered violence against doctors in general terms. Doctors were quick to tell me that violence against male and female doctors was categorically different. Dr. Mohan, an intern at MGMC who cultivated Bollywood-hero sized muscles at the gym in his free time, brushed off the threat of violence to his own body with masculine pride. He explained that violence enacted on male and female bodies has very different consequences: in a rural posting “the circumstances, the surroundings can become very violent. It can become very abusive. So, I mean, it can become really hard for a female doctor to handle those situations.
There are many instances where doctors are beaten up.... That really scares girls, [whereas] men can face that.” Furthermore, Dr. Mohan explained that violence has different implications when enacted on men and women doctors: “A man will take a beating, but if a girl takes a beating … it has a different meaning… because of the orthodox society. For the girl’s image.” The risks for women thus extend beyond the physical body, affecting her “image” and, by association, that of her relatives. Male doctors in the village are only deemed at risk once a violent confrontation has begun. Women, on the other hand, are always at risk because the risks expand far beyond the threat to her bodily autonomy. The physical body has the potential to recover from injuries, but sexual purity is an irreplaceable asset. Dr. Mohan’s juxtaposition of “man” with “girl,” both referring to doctors, also illustrates the protectionist view of women: men get to be men, while women are infantilized, therefore requiring protection.

Dr. Mohan distinguishes above between a woman’s affective response to violence – she gets scared – and society’s response – her image will be threatened. Dr. Nandini, who commuted daily to her PHC in Krishnapura from her parents’ house in Jaipur, made a similar distinction. She told me she never felt afraid to take the bus, no matter what time of day or night she made the trip. At the same time, she told me it wasn’t safe for women to be out after eight p.m. (and did not hesitate to give me advice about my own travels after dark). When rules exist that restrict access to public space for women, and women inevitably break these rules, they will be held accountable for anything that goes wrong while they occupy that space. In other words, they cannot stake a claim to that space – they are merely passing through as visitors, not legitimate occupiers.
Disciplined Bodies

A few days after news broke of the “Delhi rape,” I made my first trip to MGMC to seek permission for my research project. In an inauspicious start, I boarded the wrong bus and had to jump down halfway through my trip once I realized my mistake. After watching countless buses for routes 3 and 3A pass me by (where was the 3C I needed?), I finally boarded a small private bus – just like the kind Jyoti Singh had ridden in Delhi when the driver and his friends gang-raped her. The news was still fresh in my mind. I watched as, one by one, every single passenger got off the bus save a group of young men who were friends with the driver. The bus moved into a desolate industrial area at the edge of town. Thoughts of Jyoti Singh flashed through my mind as I considered the driver and his companions. Had I been reckless to travel to an unknown neighborhood on an unfamiliar bus service, particularly as a foreigner? I could not have completed this project without a lot of travel on public transportation. But the discourse of risk, of what women should and should not be doing in public space, hung about my every move – and made me think twice about riding private buses again, even though I was dropped off safe and sound in front of MGMC’s gates. I never managed to reason away the anxiety that followed my travels; on the contrary, it only intensified the longer I lived in Rajasthan. My body was being quietly disciplined through exposure to the idea, plastered all over the news, that cities – and the legions of private buses that travel their roads – were not safe for women.

Although my response to feminine risk was surely different from that of women who “belonged” in Jaipur, others similarly experienced embodied responses when they flouted the rules for female mobility, as they inevitably did. Dr. Shireen describes how she internalized the protectionist ideology that first came from her parents:

Before, girls were stopped from going out. Anything could happen to a girl, and the entire family’s honor will go bad. People believe this. So therefore girls
themselves stay afraid, and they themselves think about their security: am I secure or not? If not, then I won’t go outside. If I have to go outside and night comes, I will have to call mom and dad to say “Daddy, I’m here right now, after this much time I’ll return home.”

Dr. Shireen has embodied the feeling of vulnerability that comes from knowledge of risk; she has made the risk her own. Other women, such as Dr. Nandini, may transgress with less anxiety, but they cannot do so without knowing they are committing an act of transgression. Dr. Nisha and Dr. Madhu, whom I quoted in the beginning of the chapter as recognizing risk even while asserting that nothing had happened to them, assumed the entire space of the village to be risky for them. Although they did not experience danger themselves, their bodies felt the risk to be true. Dr. Madhu’s response references festivals and alcoholics, alluding to the problem of male bodies: men congregate at festivals; men drink too much alcohol. Part of the reason public space, in both city and village, is deemed risky for women is that it is assumed to be for someone else. Public space is for men, and women are supposed to be just passing through.

**Male Public Space**

On a sweltering day in May I took the bus to visit Dr. Shireen in the flat she shares with her two brothers a few kilometers away from MGMC. She met me at the main road with an umbrella to shield us from the sun as we strolled through residential streets to the very edge of the neighborhood. Outside her door stood a nimbu [lemon] tree. Beyond that, an empty field that smelled of sewage and bred mosquitoes. We ate channa and poori in the darkness of a power outage on her bedroom floor. When it was time for me to leave, her neighbor’s daughters (two, three, and eight years old) insisted on walking with us back to the main road. Dr. Shireen reluctantly agreed. It was eight o’clock and the streets were thrown into complete darkness by the power failure. The three year old started to cry halfway there. “Take them back,” Dr. Shireen
told the eight-year-old, gesturing at the toddlers. “How can I go home now?” the child replied. The street had transformed from our earlier daylit walk into an unrecognizable landscape. Everything beyond the cones of light shed by our mobile phones was in shadow. The middle-aged aunties buying vegetables for dinner were gone, replaced by groups of young men, invisible in the dark until we were nearly upon them. These young men had not suddenly appeared after dark, but they were suddenly noticeable as the only other people outside. Dr. Shireen’s eight-year-old neighbor knew that this was not a street for a girl to travel alone. We finally reached the main road and Dr. Shireen insisted on waiting with me for the bus. She left the girls standing fifteen feet back from the road, away from the clusters of teenage boys at the bus stop. Dr. Shireen looked increasingly miserable as it became clear that the bus wasn’t coming. “Maybe it’s stopped running early tonight.” She quickly agreed when I suggested hailing an auto rickshaw instead.

Women have a hard time staking a claim to public space because that space is explicitly male. The maleness of public space can be seen in the necessity of carving out women’s spaces within it, especially where bodies are likely to come into close contact. The railroad ticket counter often has a women-only window so that men and women can avoid crushing into each other in the full-body contact sport that is buying tickets. The Delhi metro’s “ladies’ coach,” advertised by hot pink flowers printed on the platform floor, is separated from the rest of the train by what seems like an invisible force field, near bursting from the pressure of bodies in the overcrowded adjoining car and sometimes reinforced by the presence of police officers. Jaipur public buses have reserved seats up front for women but are more often than not occupied by men. All but the most cosmopolitan of social events in Rajasthan have separate seating for men and women. Even husbands and wives were not supposed to spend too much time together in
public. My husband and I were teased at a housewarming party on the outskirts of Jaipur when he came over periodically to the women’s side to chat with me. He was accused of constantly thinking about sex – why else would he want to talk so much to his wife? This is precisely the message from all of these examples of separation: men and women have no business sharing the same space for anything outside the sexual realm. The assumed sexualization of mixed-gender interactions outside the home, along with the lack of discursive space for women’s sexuality outside the realms of marriage and procreation, combine to make women’s presence in male public space always suspicious. Students in the medical college hung out with boys and girls together, but they knew they were doing something different from the majority of the population. The rules could be fluid, but they started from a place of gender segregation. A medical degree and a position in the government as a medical officer lend legitimacy to a woman’s movements in the public realm, but may not entirely counteract her embodied feeling that she is doing something not quite right as she travels, often alone, to the villages under her jurisdiction or leaves her house at night to treat an emergency.

My informants generally agreed upon the rules that shape women’s movements through male public space. The intricacies and the confines of these rules change from place to place, but recognizable constellations of rules can be found throughout North India (and throughout the country, and much of the world, in many cases). Middle-class women may travel through the city during the day as long as they do so with a particular purpose: going to school, work, or shopping. Women in much of India do not have the luxury of engaging in “time pass” as men do, gathering in groups on outdoor benches to read the newspaper and sip chai, or simply milling around with no clear purpose (Jeffrey et al. 2007, Lukose 2009, Phadke et al. 2011). If middle-class women are outside, they are going somewhere – never simply hanging out. In addition,
women must perform properly feminine comportment. In her study of students from an OBC-majority college in Kerala, South India, Lukose (2009) found that young women learn to walk in a contained or demure way, with their arms at their sides and their eyes trained downwards. “The demure female body enables a young woman to enter the public, but in ways that circumscribe her movements. She must be goal-oriented and contained as she traverses a public that is also occupied by young men, whose movements and trajectories are different – aimless and wandering” (Lukose 2009, 80). Women in Kerala cultivate this demure style of walking in order to avoid the male gaze and the potential for harassment. Men police women’s out-of-place bodies (whether or not they are walking correctly) through harassment, euphemistically called “eve-teasing.”

Young women in Rajasthan similarly seek to avoid the male gaze, not only through contained walking, but also by covering every inch of skin with cloth. Middle-class college students at the bus stops along Tonk Road, a major public transportation thoroughfare in Jaipur, commonly wore jeans or salwar suits topped with thin cotton jackets, gloves that extended to the upper arm, and cloths tied deftly to cover the head and face, protecting skin simultaneously from the brutal sun and the male gaze. With each successive visit to Jaipur I saw more women on buses and scooters covering their faces – not only students but occasionally working women in saris as well. This wrapping was the ultimate instantiation of demure walking. Women’s bodies existed in the space, but they had been depersonalized. I started covering my face too, not with any expectation that it would keep my body safe from the inevitable groping that happens on crowded buses, but to keep the perpetrator from seeing how much it affected me. I hoped that, by hiding my shame and frustration (a dead giveaway to my inability to claim the space as my own), those who grope would feel less able to reinforce their own claim to the space.
Several anthropologists working with women in South Asia have argued for the liberatory potential of purdah, or veiling, a convention that keeps women out of view – but also allows women to move through space while still ostensibly following the rules for being a good woman. Papanek, writing about purdah in Pakistan, calls the burqa a “liberating invention” (Papanek 1982, 10). Gold, writing about purdah in North India, calls it “a cover behind which [women] gain the freedom to follow their own lights” (Raheja and Gold 1994, 167). And Abu-Lughod sees the burqa in Afghanistan as a kind of “mobile home” (Abu-Lughod 2002, 785).

These are, of course, different places in which purdah has diverse rules and meanings. But the idea of purdah as (at least partly) liberatory has helped me to think through middle-class women’s movement through space in Rajasthan. Doctors do not practice purdah in the way that some women, especially in villages, use the ghunghat to cover their face whenever they are in the presence of their husband’s male relatives (or any place where one of these relatives might show up, such as the street). Instead the male gaze from which they are expected to hide includes all men they may encounter while outside the domestic sphere (and, especially, the unfriendly bodies of lower-class men). While they may not be required to hide their bodies, they must hide their sexuality, the source of their risk. Their covering is steeped in a discourse of danger rather than the sharm [shame] that guides purdah, but the effect on women’s movement is similar. Like more traditional purdah, covering one’s skin – and, to a greater extent, riding in a car, which I explore in the next section – provided a proper way for middle-class women to move through space.

Medical students ranked the rules for women’s dress and travel in different places on a continuum from less conservative to more conservative. Tashvi, an MBBS student from Delhi, found the rules in Jaipur to be stifling:
Tashvi: Delhi is so different. In Delhi you have a lot of choices in your clothing. When it’s hot out, you can wear shorts – and you should – it’s so much more comfortable! Here you can’t wear shorts. I can’t even wear shorts in the campus, except for after dark when no one can see.

Jocelyn: If you do wear shorts, what will happen?

Tashvi: Everyone will stare so much. I’ll feel uncomfortable. And it’s not just boys – the girls will stare too, will judge what I’m wearing. They won’t support it. People say “you’re becoming westernized,” but that’s not a thing! What does that mean?”

If Jaipur was deemed conservative compared to India’s metros, the interior won the most conservative ranking on students’ lists. The village thus becomes a space where women are considered to be most restricted, and a space where women doctors are expected to shed some of the restrictions they are used to regarding long-distance travel and solo living. Tashvi complained about not being able to wear shorts in Jaipur, and she would certainly have gotten stares had she worn them in a village. But I would also add that there are many spaces in Delhi where a woman would feel uncomfortable wearing shorts. On my periodic trips to Delhi I saw many bare women’s legs, but only in upper-class shopping areas and restaurants; these legs must have been ferried from their owner’s home to the bar in Defence Colony or Khan Market in a car with rolled-up windows and AC. I mentioned in the previous chapter that these spaces of consumption were missing in the village (and spaces where women could comfortably bare their legs were largely missing in Jaipur as well). Bare legs mark a space as cosmopolitan and therefore as ostensibly safer for women; it follows, then, that villages, spaces where women’s legs remain hidden under salwars, lehengas (traditional rural dress in Rajasthan), and saris, subscribe to a whole host of restrictions on women’s bodies. These restrictions, far from making doctors feel protected, made the space of the village more threatening. Doctors living in a place with conservative rules are less able to stake a claim to be there as working women.
Village doctors also had to give up the support of their friends and family members who made it easier to get around. Dr. Shireen, who did not like to take the bus at night, relied on a medical student friend to drop her home on the back of his motorcycle after their evening PG-exam coaching sessions. Dr. Kavita’s car tire burst one day on her way to her clinic in Jaipur, so she hailed an auto rickshaw and called her father who sent someone out to fix the car while she was at work. “So in the city the facilities are good,” she elaborated. “In the villages it’s not like that.” Buses only came to villages once or twice a day, and the only other transportation was shared jeeps, often crammed full of people. “When I was in the PHC, my room was really far,” she continued. “There you don’t get any rickshaw, any auto. The PHC was really far. I had to walk. And there was a shortcut, but it was through the sand – the desert. So it took a lot of effort to go. I got tired! And in the hot sun… so I brought an umbrella.” Here Dr. Kavita is not speaking explicitly about danger, but she contrasts her ability to move comfortably in the city (even when her car breaks down) with the difficulties of village mobility.

Shilpa, an MBBS student, told me the story of her recent birthday party as we sat in her hostel room one afternoon. Her family came from another city to visit, and after eating out they returned her to the hostel at eleven p.m. Then her friends whisked her away to a surprise party at the fields of the Jaipur airport, where they stayed until two thirty in the morning. After listening for months to women tell me about the restrictions on their movements, especially after dark, I was very surprised – how had this happened? The answer lies in Shilpa’s social network. She could not have gone alone for dinner until eleven at night. She certainly could not have gone alone to sneak into the air fields late at night. She had friends, both boys and girls, who, through their critical mass, changed the desolate space of the air fields into a welcoming one. The
necessity of being alone in a rural posting, especially at night, left medical graduates wondering how they would make it work.

Mahima, a medical student, grew up in Delhi but visited her father’s home village in Rajasthan’s Jhunjhunu district frequently. She enjoyed spending her vacations in the village with her doting grandmother (and eating her grandmother’s food, which I got to sample in the form of homemade sweets brought back to the college and stashed in Mahima’s hostel room). But being in the village required her to live differently, particularly when it came to social relationships. She told me about a boy who had been her friend in childhood. Now that she is older, she can no longer talk to him. When she walks down the road from the bus stop to her house she keeps her eyes averted and won’t talk to the groups of boys hanging out in the road. Mahima’s childhood friend recently tried to connect with her on Facebook but she denied his request; she thinks they have nothing to say to one another and have no reason to be friends – and that she would face severe disapproval if they were ever seen together. She was also wary of befriending boys in the medical college, fearing the possible repercussions: “if something happens, whose fault will it be? Girls need to set boundaries.” While the surveillance Mahima experienced in the space of the village restricted her social relationships, it simultaneously provided a feeling of safety and belonging. The village in which Mahima spent her vacations was her village, filled with people who knew her and looked out for her. Returning to work in this village would mean returning to her roots; working in a village where Mahima is unknown, what another medical student described as a “village of strangers,” would have a very different connotation.
Purdah By the Dashboard Light

One tactic to achieve greater mobility, available only to some doctors and therefore a marker of difference, was driving a car. Cars greatly reduced the perceived risks of traveling through public space for the women in my research. I have no data to support the claim that they actually reduced the risk of harassment and violence. Yet cars were able to perform some kind of symbolic magic that rendered their inhabitants protected from reputation-tarnishing dangers.

Owning her own car allowed Dr. Anandi to stay at her village post and visit her young son, who lived in Jaipur, on the weekends. She had many problems with this arrangement, mostly that she missed seeing her child, but safety was not one of them. Dr. Madhu, a PG student at Ratna Hospital in Jaipur, drove once a month to visit her three-year-old child in Jhunjhunu, a distance of just under two hundred kilometers. “I drive by car,” she told me. “It’s such a long and boring journey! But it’s ok because I’m crazy to meet my child every month.” The boring nature of this trip is exactly what makes it possible. A “boring” task has no room for risk or danger – in its mundanity, it is implicitly safe.

Things can go wrong, of course, when traveling by car. Dr. Kavita told me a story of traveling on her rounds from one subcenter to the next, part of her responsibilities as a rural Medical Officer, when she had to pull her car to the side of a narrow road to allow a bus to pass by. The car got stuck in the sand on the road’s edge. To make matters worse, she found that her cell phone was out of range. But all ended well – she hailed a farmer who happened to be working in a field nearby, and he helped her push the car out. Despite the potential for women doctors to be stranded, alone, in the middle of nowhere, cars maintained an aura of protection. And cars contributed to the image of women doctors as independent women. Dr. Kamala, an obstetrician gynecologist many years into her career at Ratna Hospital, a private hospital in
Jaipur, told me her mother had encouraged her to become a doctor, telling her: “Look at how independent these lady doctors are! They drive their own cars!” Indeed, the doctors I met who worked in the government sector tended to drive their own cars, rather than hire a driver. And driving oneself avoided the tensions, analyzed by Amrute (2015), implicit in working women being chauffeured back and forth to the office by drivers, where the safety of a private car bumps up against the threatening presence of a lower-class male driver – two bodies forbidden from mixing yet sharing an intimate space.

Dr. Pratiksha, the medical college professor, longed for a car. She used different methods to get to work every day: the public bus, or an auto rickshaw, or occasionally her scooter, although she felt it was a long trip to take on a two-wheeler. One day I was walking outside the medical college when a woman came up behind me on a scooter, honking. She was covered from head to toe in cloth: over her sari was a long-sleeved cotton jacket, and a scarf covered her head and face. It was only when she pulled the scarf down that I recognized Dr. Pratiksha. She chose to cover every inch of skin because she did not have the protection of a car. She was not alone in this lack; car ownership was not at all ubiquitous among the women doctors I worked with, making it an important marker of difference. Cars constitute an extremely expensive care for the body, after all. For Dr. Shireen, cars were conspicuous in her life story by their absence. In the midst of arranging a potential match for Dr. Shireen, her parents’ negotiations broke down when they reached the topic of dowry. She said, “People ask for a car in dowry. My Papa hasn’t even seen a car; how can he give one in dowry? He said that we’re giving a doctor girl; she will earn for you. But they say it is a thing of honor [izzat] for us, that a car will come to us in dowry.” In contrast, Dr. Pratiksha earned enough money through her job at the medical college to cover the cost of a car. She did not have one because she had little control over how her salary was spent.
Her husband and father-in-law both had cars, but, because her work was considered a choice rather than a necessity in the household, she received little support for it. She thought that it would take her two or three years to save up enough from her own allowance to get a car of her own.

Car ownership allows women doctors to range far and wide as they keep the government health care apparatus chugging along. For women who work the night shift at an urban dispensary, or live in the city but commute daily to their village post, mode of transportation can be a big deal. Yet cars are hardly an ideal solution to women doctors’ mobility problems. According to the Times of India (2014), five hundred new non-commercial vehicles enter the streets of Jaipur every day, adding to congestion and pollution. This is clearly not a sustainable state of affairs. Cars can also be lonely. Driving long distances alone seems to me a distinctly un-Indian activity, and yet many women doctors do it in order to juggle the demands and desires of career and family. I am not arguing that Rajasthan’s public health problems can be solved if every woman doctor manages to buy herself a car. Car ownership is merely a way to work around a larger problem – that of the discourse of risk that keeps many women closed off from the public spaces of both city and village.

The Risk in the Crowd

For my first trip to Krishnapura village to meet Dr. Nandini, I came unannounced by taxi – a quick afterthought to the nearby CHC we had visited to do a scheduled interview. As the taxi driver wandered off in search of a cup of chai, I climbed Krishnapura PHC’s concrete steps and slipped inside imposing half-closed metal gates, watched with indifference by two cows reclining in the sand. Dr. Nandini was not in today, according to the pharmacist who had taken
her place behind the desk to prescribe medicines. The pharmacist would only vaguely commit to knowledge of the doctor’s plans: “she might be back tomorrow.” I had to come back twice more before I finally met her. After I learned that Dr. Nandini would not be coming in, I had settled myself onto the front steps of the PHC to await the taxi driver’s return when an elderly man approached. “Who are you? What are you doing here?” he wanted to know. His local Rajasthani dialect and my Sanskritized textbook Hindi made for stilted, yet pleasant, conversation. As we talked, more and more men came up and formed a press on all sides of me – no doubt curious as to what an Angrez [white foreigner], and a woman, was doing hanging out by herself in the main yard of their village. As the crowd gathered I felt increasingly apprehensive, locked in a circle of the very people the discourse of risk had told me where dangerous. One friendly old man had seemed innocuous; a village’s worth of men seemed something altogether different.

If men pose a threat to women, then it makes sense that crowds of men pose a proportionately greater threat. Dr. Meenakshi, the head doctor at Devipura CHC in Dausa district, described the discomfort she feels when faced with a crowd:

If a man gets in an accident, twenty gents will come with him to the hospital. They will form a crowd around him. If it happens at night, most likely they will have been drinking. To reach the patient I have to push through the crowd of men and touch them. I don’t like this. They’re yelling at me: “hurry, hurry!” I don’t like it. I feel uncomfortable. If one man comes to the OPD, then that’s fine – I feel comfortable treating him. But I don’t feel comfortable when a crowd of men comes.

The agency asserted by the “twenty gents” as they try to save their friend transforms, in Dr. Meenakshi’s experience, into a direct threat to her bodily autonomy. I could relate to Dr. Meenakshi’s discomforts. Knowledge of the arbitrariness of discourse on risk did little to protect me from gendered anxieties that, with time, began to feel natural and obvious, even as I worked to dismantle them.
I struck up a conversation one day with Purnima, a conductor on the public AC2 bus route. Jaipur’s AC buses were newer and scarcer than the usual open-windowed variety; they blocked out traffic fumes but did not necessarily make passengers any cooler as the sun poured into sealed windows on a hot day. Purnima was in the minority as a female bus conductor, a male-dominated occupation in Rajasthan. She had a master’s degree but could not find a job in her field, so she settled for convenience over a high salary – the bus route allowed her to be home in the early afternoon to be with her kids after school. I asked her if she ever experienced any harassment in her job. Purnima told me that she didn’t get any trouble from the boys on the AC bus route (it was mostly filled with college students), claiming that boys of this class status “knew better.” For Purnima, problems arise from uneducated people, those who don’t “know better.” As I showed in Chapter 4, a lack of formal education is linked in doctors’ imaginations with a propensity toward violence, but this connection can be found beyond the medical world.

Suspicions of lower-class men not “knowing better” create a population of marginalized men who are labeled a threat to respectable middle-class women. The male bodies who are the source of so much worry for women doctors are assumed to be lower-class, with “perverse and uncontrollable” sexual desires that fuel their aggressions against women (Puri 1999: 100). Das (1995) found a similar discourse in her study of judicial language in court cases handling sexual violence. According to one verdict, young men are only “acting out their impulses and ‘irrepressible sexual urges’ when they rape women” (Das 1995:2420). Judicial discourse thus naturalizes male sexual desire for female bodies, as well as the inability for some men to control these “natural” impulses. Purnima’s statement above suggests that these naturalized urges can be countered by education, which is intimately linked with class status.
The attribution of risk to certain kinds of men likewise crosses intersecting lines of identity beyond class to include Muslim and Dalit men. Since the partition of India and Pakistan in 1947 and the communal violence that ensued, much of it sexualized, Hindu nationalists have crafted an image of Muslim men as sexual boogeymen and as general scapegoats for India’s problems (Anand 2005). The image of Muslim men as threatening Others (increasingly portrayed as terrorists in the twenty-first century) carries on in blockbuster Bollywood films (Kumar 2013). Likewise, dominant-caste Hindus have resented the gains made by Dalits in education and government careers and often see Dalits as a threat, which can easily slide into a sexual threat against the purity of upper-caste women (Chowdhry 2009). Discourses of Muslims and Dalits as threatening certainly circulate through upper-caste Hindu conversations, pulling a wide range of men who are “not us” into the category of threatening Other. While casteist and Hindu nationalist discourses of dangerous men circulated in Indian popular culture, doctors, like the bus conductor Purnima above, tended to speak about dangerous men in terms of class and educational status. Low class status, and the lack of formal education that accompanied it, crossed caste and religious lines and was available to all doctors as a marker of the Other who threatened women’s bodies and reputation.

Stoler (1989) examines risk and respectability in a different time and place (throughout European colonial territory) but finds strikingly similar concerns and repercussions. Once European women joined men in the colonies, they supposedly needed protection “because men of color had “primitive” sexual urges and uncontrollable lust, aroused by the sight of white women” (p. 641). Stoler argues that anxieties about women’s respectability were intimately connected to boundary making between the colonizers and the colonized, which resulted in increased surveillance of both European women and local men. Moreover, while there may have
been actual incidences of sexual violence enacted by local men on European women, “their incidence had little to do with the fluctuations in anxiety about them” (Stoler 1989, 641). Stoler found similar fears of sexual violence in different colonial contexts throughout Africa and Asia, implying that these anxieties, and their corresponding surveillance and restriction of movements, were a common way of dealing with the threat of social mixing.

When thinking about risk to women’s sexual purity in the space of the Indian city, risk is often assumed to arise from rural or peri-urban migrants to the city, considered to be under-educated and under-employed with plenty of time on their hands to cause trouble (Amrute 2015, Phadke 2013). The risk is located in the body of the lower-class rural man; he is conjured up when doctors speak of the rural population as “backward.” Urban attempts to curb violence against women often entail clearing the city of the “unfriendly bodies” of lower-class migrant men (Phadke 2013). The discourse of risk thus provides justification for the policing of both middle-class women’s and lower-class men’s bodies, and, in both cases, it can be used to justify violence: against women, who “deserve” it because they are stepping outside of respectable bounds, and against men, who are assumed to pose a threat. When women doctors leave the city to work in a village, therefore, they are entering the belly of the beast, the origin point of unfriendly bodies. The very presence of village men, especially large numbers of village men, is seen as a potential problem for women. The village becomes an imagined space filled with bodies that threaten an urban, middle-class woman’s reputation and bodily integrity. This runs directly counter to the risk assessment of Mohan Bhagwat of the Hindu nationalist RSS, whom I quoted at the beginning of the chapter: “rapes take place in cities and not villages.” Bhagwat is calling upon a Gandhian trope of the peacefulness and morality of village life (something Ambedkar’s writings, and plentiful evidence, clearly contradict). For Bhagwat, and for many
politicians, rape is a result of Westernization, particularly a sexualization of women’s bodies as evidenced by Western-style clothing and interactions with non-related men in public, a process seen to be taking place in large cities but not in villages. Medical students and young doctors living in the city did not buy this line of reasoning. Like Jyoti Singh, they wanted to go out to movies and malls and coffee shops. If these were evidence of Westernization, then Westernization was bringing joy to their lives. In their calculation of risk, the space of the village, empty of friends and family and full of the wrong kind of people, was the one to worry about.

For all of the stories of risk and danger, women working in villages were able to offer counterpoints to the narrative that all lower-class, rural male bodies are threatening, in addition to their stories of troublemakers: for example, when the farm laborer helped push Dr. Kavita’s car back onto the road, she expressed how relieved she was to find this man in an otherwise desolate place. And, as Dr. Divya told me (in Chapter 4), not all people in the village are bad – it is merely the situation that is bad for doctor-outsiders. Yet stories with rural heroes, or of the mundane everyday interactions of doctors and patients, do not seem to circulate among medical students as they plan their careers around rural bogeymen. The stories that stand out are the ones that fit into the discourse already available to urban medical students: that rural men are “backward” and therefore dangerous.

**Living Alone**

When I moved from Jaipur to Vijaynagar village I asked my husband to come drop me off. “Ugh… why?” was his response. Why should he have to travel so far only to turn around and return home to our flat in Jaipur? In my eyes, however, this performance – the transfer of my
protection from husband to village homestay family – was important. I wanted village residents to see me as a proper woman following proper protocol, even if my presence in the village as a foreign researcher was a curious anomaly. Women in Rajasthan are expected to remain under the protection and surveillance of their fathers and then husbands. Women need not stay home to fulfill the requirements of this surveillance; indeed, it is common for women to travel to a new city for education or work. In cities, women find an infrastructure of hostels and paying guest accommodations, institutions with guardians and curfews to track the comings and goings of residents. It is unusual in Rajasthani society for a woman to live on her own without the protection of a relative or guardian who occupies the parental role. Even in the most cosmopolitan Indian cities it can be difficult for an unmarried woman to find housing if she wants to live by herself (Fernandes 2006, Phadke 2007, Sharma 2014). Some landlords assume that single women looking to move into a flat (rather than stay with a family or in a hostel) must be of questionable character. Other landlords do not wish to undertake the paternal protectionist role that is socially expected of them, keeping tabs on the woman’s movements and visitors.

Under most circumstances, therefore, it would be unusual for a young woman to live by herself, far from her social network and far from the accommodations that make cities accessible to young women from elsewhere. Yet this is exactly what the current public health infrastructure requires. Many, but not all, PHCs provide living quarters to encourage the doctor to reside locally, cutting down on absenteeism. This arrangement assumes that a doctor can move to the quarters either by herself or with a family in tow. For unmarried women, or married women with husbands working elsewhere, such a move presents great difficulty.

Dr. Nandini joined Krishnapura PHC as a Medical Officer shortly after finishing her MBBS. She was the only doctor there, accompanied by a few other staff members including a
female nurse. She rented a room in the village for her use during the day where she could use the bathroom and eat lunch. But she and her parents decided that staying in the village overnight, alone, was not an option for her. Instead she lived with her parents in Jaipur, around fifty kilometers away, and rode the bus daily – a serious, but necessary, annoyance. Dr. Kavita, who was married by the time she took her first posting at a rural PHC, described the precautions she took when her doctor husband was posted seventy-five kilometers away:

> At night to keep safe I didn’t go out. No one does. If you live alone, your parents are far away, husband is far away… why take a risk? In this way I kept safe. I have told you that I didn’t live in the quarters. Why not? For safety. Living in the quarters alone, anyone could come at night and knock and take you away.

For Dr. Kavita, being alone is itself a danger. The specters her story invokes cannot simply be avoided by staying in – they threaten to breach the boundaries of domestic space. Instead of staying alone in the quarters, Dr. Kavita moved in with an ANM who lived with her sixteen-year-old son. This provided her with a makeshift family and, importantly for her image in the village, male protection. Some women doctors are able to make arrangements like Dr. Kavita’s. But doctors who are men need not spend time and energy worrying about, and arranging for, their own bodily protection in the same way.

**Marriage and Opportunity**

I sat on Mahima’s bed in the MG girls’ hostel while she presented two of her friends, persuaded by Mahima’s friendly entreaties to come in from the hallway, as interview subjects. “Do you plan to get married?” I asked the newcomers. Much laughter ensued at the absurdity of my question. “Of course!” interjected Mahima on their behalf. “Every girl in India will get married, otherwise people will think there’s something wrong with her. We all have to get married.” Whether or not women like it, heterosexual marriage, in all but the rarest cases arranged by the
family, is a social requirement in Rajasthan. Dr. Sonali, a medical officer at Rajghar PHC, was unusual in that she was determined not to get married when she entered medical college. “I never wanted to get married because there are so many boundations. My mom and dad have raised me as if I was a boy. And I understood that, anything that’s good now, I won’t be able to have it after my marriage. And then my father had a heart attack, so it seemed to me that… [if I get married] who will look after him?” What transpired next was classic Bollywood: “What had to happen happened! [laughing] My husband, he wanted very much for us to get married. I refused several times, saying no, no, no, I can’t do it. But still he forced it. Then somehow or other he persuaded me that we should start a family.” Dr. Sonali was the only doctor I met to have a love marriage, and while neither family had abandoned the couple, it created tensions between Dr. Sonali and her in-laws resulting in a lack of support for her career and her domestic life.

Marriage could have a dramatic impact on the careers of the women I met. In some cases, a married woman’s new family could restrict her career opportunities. For example, Dr. Sonali, who had a PG degree in pediatrics but was working as a medical officer, wanted to leave Rajasthan to find an area with more specialist jobs; her husband insisted that they stay in his home district to be near his parents (sons, and their wives, are the traditional caregivers for parents as they age). Dr. Sonali had feared the “boundations” that came with married life for good reason. But for women working in rural areas, marriage was more likely to generate opportunities otherwise unavailable. It was not the mere fact of marriage that helped women, but the opportunity for a woman to be posted near to her husband or husband’s family – this could expand the geographical range of possibilities considerably. Dr. Asha told me she was able to take a rural posting only because her then fiancé was posted nearby. Without this, she says she
would not have entered government service. While Dr. Kavita’s first rural posting was far away from her husband, she managed to be placed in a village near her husband’s family. She said:

Why didn’t the people in my first posting bother me? Because it was near my district [where she had moved after marriage]. People there knew my in-laws. So I got a bit of a benefit…. There was a cow farm there, and it was the same farm that supplied my house. So that family gave me a bit of support. Because of this there wasn’t anything to bother me.”

I met several doctors now working in Jaipur who avoided rural careers primarily because their husbands could not join them in the village. Dr. Kamala, who has spent her entire career working in the private sector in Jaipur, declined a rural posting after graduating from medical college because her non-doctor husband would not have been able to accompany her – it was inconceivable for him to follow her to a village where he had no job prospects. Dr. Bela, who now works in government service in Jaipur, turned down her first village posting because her doctor husband was working across the state in Jodhpur, a city in western Rajasthan. After a month and a half she was transferred to a village in Jodhpur district. Dr. Bela was closer to her husband in the city but not close enough to make it safe for her to stay in the village, where there were no other women posted in the clinic. As a result she commuted to work, admitting that she only went to the village about once a week. Dr. Bela kept this posting for three months until she was transferred to the city with her husband.

The only women I met who were able to sustain a long-term rural career were married to doctors who were posted in the same village or nearby. Dr. Anju has been in rural government service for twenty years. She did not accept her first posting until after she was married and her doctor husband was able to work in the same area. Since her marriage she has been lucky – she and her husband have been transferred six or seven times, but always together. She currently works in a village bordering the city limits of Jaipur. It looks like a village and has many of the standard rural problems (for example, the water is salty and Dr. Anju has to import drinking
water), but is only a few kilometers away from the city limits of Jaipur. Because of its proximity to the city Dr. Anju’s post is seen as a relatively cushy job compared to most other rural areas. But Dr. Anju has worked successfully in many different village settings more remote than this for two decades – and attributes this success in large part to her ability to work in the same place as her husband. Dr. Meenakshi works a much less cushy job, at least in terms of its proximity to Jaipur where her son attends school. Her husband works alongside her in the CHC. Her first posting was in her home district of Jodhpur. Her husband was in Jaipur doing a residency during this time, so she lived with her father in Jodhpur and commuted to her village PHC. In six months her husband finished his residency and was posted in another district too far away for an easy commute. He declined the posting, and together they approached the health minister to request a transfer to the same area. Since her entry into the government sector nearly twenty years ago, most of her postings have been in the vicinity of her husband: “our priority is to be together.”

These doctors have found a way to sustain long-term rural work despite the discourse of risk because the presence of their husbands, fathers, and in-laws dramatically changes the terms of that risk. If, as I have argued above, the severity of risk increases as a woman moves farther and farther from the shelter of paternalistic surveillance, it follows that the presence of one’s husband (or father before marriage) offsets the risk. Women are as mobile as the umbrella of surveillance carried by their kin. What happens, then, to women who opt out of compulsory heterosexuality and its bedfellow, marriage? This is a difficult question for me to answer based on my research. The one woman doctor I found who was well into marriageable age but remained unmarried evaded my attempts to interview her. She worked in Jaipur city, not the village, so her case (as far as I know it) does not offer any glimmer of hope for rural service
where unmarried women are concerned. My research only reinforces the compulsory nature of heterosexuality, where remaining unmarried is nearly unthinkable, and where the respectability of heterosexual marriage allows women the opportunity to expand the umbrella of surveillance, and their career possibilities, into new territory.

**Conclusion**

A surprising finding from Phadke’s (2007) study of Mumbai women shows that, in some ways, women actually felt less safe in their own neighborhoods – the very spaces where they are under the most surveillance. “Rather than empowering women, the presence of insiders (and the pressure to demonstrate respectability: “good women ignore sexual harassment”) actually prevents women from acting in their own defence [sic]” (p. 1513). Only one of my interviewees, medical college professor Dr. Pratiksha, talked explicitly about escaping the paternalistic gaze. She lived in Jaipur in the same house as her parents-in-law but did everything she could to carve out a space for herself away from them. She managed an essentially separate household for herself and her children, cooking separate meals in her own makeshift kitchen. She captured time for herself by parking her scooter away from the house and picking it up after returning from work by bus, when she could go shopping or to the beauty parlor without having to account for her movements. One could imagine, then, rural spaces providing some aspect of liberation for women doctors who are able to move around without needing to tell someone first, or could defend themselves against potential aggressors without worrying about sullying their reputation. But I never heard rural spaces described in these terms. No one who had worked in a village talked about it in terms of freedom, of the ability to wander around without having to account for
their whereabouts – perhaps because, unlike in the city, there was nowhere they wanted to go. Instead, women talked about the distance from their family only in terms of danger and threat.

I return briefly to the story of Dr. Divya who left her rural posting after only eight days, foregoing the government sector altogether. She told me only that the village was a “disturbed place” not suitable for women doctors. Her reluctance to tell me the details of what happened to her was a common occurrence; even talking about violence against women seemed to place women too close to the threat of shame to be comfortable (see also Dewey 2009). The discourse of risk that shaped middle-class women’s lives generated a vague sense of danger for middle-class women who entered rural spaces. Narratives focus on the threats posed by unknown village men whose very presence is deemed dangerous. And decisions to reject village work, as in Dr. Divya’s story, reinforce the idea that women doctors are social outsiders in village life without protection from potential threats. The question that remains is, who will come to fill in the spaces left by Dr. Divya, Dr. Kamala, and Dr. Bela? There do not seem to be enough women who fulfill the criteria necessary for success in village work. How, then, can the risks be mitigated to allow more women doctors to serve the rural population? Some doctors felt that the locus of change should be the village itself, or at least its residents: if village men would only behave better, rural spaces would become safe for women. As I have shown, however, the problem extends far beyond the bodies or behavior of village men. The discourse of risk that frames middle-class women as being in need of protection, and that constrains their movements away from the surveillance of their families, lies at the heart of the problem. In the next chapter, I explore how the public health apparatus deals with (or is able to ignore) the problem of middle-class feminine risk.
CHAPTER 6
“LADY DOCTORS DON’T HAVE PROBLEMS”:
STATUS AND DIFFERENCE IN PUBLIC HEALTH DISCOURSE

Introduction

In this chapter I explore the invisibility of women doctors’ problems under the health
administration’s gaze. While government health administrators think very hard about gender
when it comes to some women – namely those from disadvantaged groups in terms of class,
caste, or rural residence – I could not find evidence of anyone in Rajasthan’s public health
bureaucracy paying attention to the problems that kept women doctors out of villages, despite
publicly available statistics on the lack of women doctors in rural areas. The problems poor
women face are well known in India, and, following recent global trends, have led public health
policymakers to bring a “gender lens” to bear on health care. But gender in this context always
and only pertains to the poor women who are the objects of public health interventions, not the
professional-class doctors who act as agents of development via improvement of health and
demographic indicators for the population. The women who are framed as targets of
development and empowerment projects are the patients who utilize the government health care
sector, or the low-status women’s health workers who provide front-line care. Women doctors,
by their very position as the bearers of development, cannot themselves be in need of
development. While it is not always clear exactly who is “already developed” and who is in need
of development (Pinto 2008), a doctor’s legitimate biomedical degree places her on a different
plane from the community health workers with varying levels of state or NGO training that
populate the rural landscape.
I argue that women doctors occupy a tension-filled space that does not fit comfortably within development and empowerment discourses. Women doctors have historically been seen as different from other women in their role as agents of population-level improvement. Public health policy likewise assumes women doctors’ autonomy and mobility in filling rural postings. But the women themselves are neither autonomous nor mobile in the way public health officials envision. As I have shown in the previous chapter, the performance of middle-class feminine respectability constrains women doctors’ mobility through public space. Their degree does not obviate their need to remain under male protection. When women doctors are asked to move beyond the reach of the paternal gaze, their status as already-empowered women breaks down, and yet this breakdown is not visible to the health administration. With this chapter I aim to show that the exclusion of women doctors from any discussion of gendered risk or discrimination is shaped by discourses of development and empowerment that create a binary between the subjects and objects of development with little discursive space in between.

*Visible Bodies, Invisible Doctors*

Highly visible indicators of health and development such as maternal mortality, infant mortality, and HIV infection rates bring certain women’s bodies under the health administration’s spotlight. In Chapter 2 I outlined some of the National Health Mission (NHM)’s twelve *yojanas*, or schemes, for women and children’s health that were active in Rajasthan during my fieldwork period. These *yojanas* function to transform patient behavior, bringing poor women’s bodies in line with officially designated biomedical protocol: regular perinatal checkups, institutional deliveries, planned reproduction, and sterilization after an appropriate number of children. The *yojanas* ultimately address the NHM’s larger project of reducing Rajasthan’s high rates of
maternal and infant mortality. The *yojanas* also bring the focus of the public health gaze to bear on the bodies of the schemes’ recipients: poor women. The bodies of these women, deemed overly fecund and biomedically non-compliant, become hyper-visible in their failures as they contribute to population growth and maternal and infant mortality rates that bring embarrassment to the state.

Women doctors, on the other hand, are largely missing from the gaze of health administrators and from the pages of strategic plans in the health sector. The absence of women doctors in rural areas is noted in official accountings without garnering any action in the NHM’s strategies. The NHM records the number of PHCs in each state that host at least one women doctor, meaning that the availability of women doctors in rural areas does register enough to make this an issue worthy of statistical tracking in yearly progress reports. Beyond this statistic, however, NHM publications are silent on the placement of women doctors in rural areas. Documents charting the successes and failures of the NHM (see GOI 2010) group medical officers together without a mention of gender. In official documents, “lady doctor” is a marker of difference, occasionally (but not necessarily) appended to the medical officer category. Other clinical roles, such as ANMs and ASHAs, are explicitly gendered from their very inception (Jesani 1990). ANM and ASHA positions fill two separate but related functions: to encourage family planning while also improving health outcomes for women and children, and to empower the women who become ANMs and ASHAs through education and practical training. Thus, ANMs and ASHAs are explicitly linked to developmentalist goals, and make sense only through their position as female occupations.

While NHM administrator Nidhi Madam listed Rajasthan’s *yojanas* for me in the NHM’s offices, one of her colleagues approached, probably curious about the foreigner who had shown
up so unexpectedly in their workspace. He pulled up a chair to join us. After I explained that my research is on the difficulties women doctors face in their work, he told me: “lady doctors don’t have problems – they only have the same problems male doctors have.” This statement took me aback; after all, I had spent much of my research period hearing stories that argued the exact opposite. How could this public health official’s perception of the experiences of women doctors be so different from what I had been hearing? The public health official went on to explain that it was the ANMs who faced problems. He illustrated the vulnerability of ANMs with a story about someone throwing rocks at an ANM’s house. Research has highlighted the problems ANMs and other women health workers without a professional degree face in their position at the lower end of the health care provider hierarchy. Mishra (1997) describes the work conditions for women health workers as follows:

FHWs [female health workers] working at PHCs and sub-centres are exposed to and confronted with many risks and dangers in the scattered and scanty villages. They live alone, far from their families, at PHC and sub-centre. Usually the sub-centres are located outside the villages. Houses are not in proper shape. … Their job demands odd time visits in the community which creates many problems for them. They do not get the desired respect and co-operation from the community. Living in such a pathetic situation, they are not even treated sympathetically, rather [they are] blamed for the failure of any health and family welfare programme by the higher officials and the community as well (Mishra 1997, 2791).

In a study of ANMs in Maharashtra, Jesani (1990) found a general consensus among male health workers (at the same occupational level as ANMs) that “no good woman takes up ANM’s work” (Jesani 1990, 1101). ANMs were seen to be sexually available because they often lived alone, their work required them to travel from house to house and village to village, and they talked to other women about sex, which, as one male health worker put it, “only prostitutes can talk about… so freely with so much knowledge about it” (Jesani 1990, 1103). This perception shaped their treatment in the community and their ability to do their job (which, in the early 1990s,
depended on reaching family planning targets). The entire community knows about the harassment directed at ANMs. ANMs are visible because of their low status in the community – they are expected to have problems. What is interesting to me about the statement made by Nidhi Madam’s colleague, when he claimed that “lady doctors don’t have problems,” was that he assumed that, because ANMs had these problems, lady doctors could not. While ANMs attract the public health gaze, doctors slip by unnoticed due to this difference.

The NHM is not alone in their equation of gender-based problems with lower-class women. Subaltern women are a favorite topic of social scientists, feminists, and public health advocates, for good reason. In the past few decades, these scholars and activists have sought to shed light on gender issues in health care delivery. A group of researchers reviewed medical textbooks used in Indian medical colleges in a special edition of *Economic and Political Weekly* to highlight the gender blindness in the Indian medical curriculum (Agnes 2005, Bha and Acharya 2005, Davar 2005, Gaitonde 2005, Iyengar 2005, Khanna 2005, Kutty 2005, Nagral 2005, Patel 2005, Prakash 2005, Sudhakaran 2005). For example, feminist and judicial activist Agnes analyzed commonly used textbooks of medical jurisprudence and forensic medicine. She found that “the presumptions are always against women, that women are prone to file false cases of rape and that it is up to the doctor to exercise caution while examining a victim of alleged rape” lest the doctor also be falsely accused (Agnes 2005, 1859). In addition, Agnes saw little discussion in these texts of the gender inequities that lead to domestic violence and dowry deaths. Textbooks often lack any information about gender, giving the impression that it is not important, or they reproduce stereotypes that are harmful to women. The general consensus in these articles is that gender theory has not made its way into the Indian medical curriculum. Another study of gender sensitivity in medical education, conducted by the Centre for Enquiry
into Health and Allied Themes (CEHAT) in the southern state of Maharashtra, generated similar results. CEHAT discerned no improvement in gender-based medical education between their initial study in 2002 (Jesani and Madhiwalla 2002) and a follow-up in 2014 (John et al. 2015). Other studies outside of medical education seek to highlight gender issues in reproductive and child health policy (e.g., Kumar 2002).

These efforts by feminists, activists, and public health researchers are extremely important for the provision of health care and represent a crucial branch of India’s feminist movement. The research published by CEHAT and Economic and Political Weekly presents compelling evidence that gender-based inequalities and discrimination in health care remain a serious problem in India. What stands out to me in this literature, however, is how infrequently the concept of gender is invoked when thinking about health care providers rather than patients. The focus of gender research in health and medical education is the gender of the patient, or that of low-status women’s health workers. This research argues that doctors need to be retrained to see how gender disparities affect their patients. But nowhere is there mention of gender as it relates to the body of the doctor, inadvertently compounding the invisibility of doctors when it comes to gender. The major marker of difference in this body of work lies between those who are the recipients of health interventions, for whom gender is an important aspect of identity, and those who provide medical care, for whom gender appears largely irrelevant.

The Construction of Women

In Chapter 2 I considered the colonial discourse, formed in part by the assertions of medically-trained foreign women, that accepted the logic of gender segregation and required women doctors to treat women patients. This discourse naturalized the logic of intimacy between women
even as they came from vastly different social locations. For lady doctors working in the colonial era, women were similar enough to attend successfully to one another’s health care needs, while men were different enough from women to be shut out of the realm of women’s health. But women must be different enough from each other for one group to be framed as being in need of saving while another is framed as their saviors. The descendent of this colonial ideology that I have termed the female seclusion paradox shows up in more recent discourse on women in India. This discourse is no longer all about seclusion, yet it still retains a sense of access, separating those women who can perform a modern set of behaviors, and those women who cannot – and therefore need the help of others in order to become empowered. John (1996) argues that Indian feminism in the 1970s created a marked contrast between a middle-class “self” and a lower-class “other,” the object of the movement’s study and intervention. This other included women who were poor, worked in poorly paid jobs, faced a triple burden of income-generating, reproductive, and domestic work, suffered from domestic violence, etc. In other words, “Indian feminism was formed through an active process of representation, with the need to speak on behalf of the vast majority of the nation’s women” (John 1996, 126). For John, this process of differentiation created a specifically Indian feminism: “paying attention to the lives of women who were less privileged was often precisely the way in which a middle class movement could proclaim its Indianness” (John 1996, 128). This categorization, then, created two groups of women and marked them both as Indian through their very interaction.

Scholars have also found fertile ground for a discussion of the discursive representation of women through women’s interactions with the state. As the various actors and institutions that make up the state decide on appropriate services for women, women become differentiated from one another along particular lines: good or bad, normal or deviant, Hindu or Muslim (Sunder
Rajan 2003). At the same time, “the rights of “citizenship” propel women into an equal and “same” identity with men and other women,” enabling women to make demands of the state and flattening difference in the eyes of the state (Sunder Rajan 2003, 2). Thus state actors have a complicated relationship to the category “women.” Most relevant to my research is women’s interaction with the Rajasthani state’s health care services. As I showed in Chapter 2, services geared specifically toward women are inextricably bound with national anxieties over population control and a surfeit of babies. Population control measures define some women as reproducing the population in a modern and appropriate way, while other women have too many children, burdening a state that counts its people using “Malthusian arithmetic” (Rao 2004). Those who advocate, on behalf of the state, for reproductive health services assume that certain women – those living in poverty, in rural areas, with little education – cannot make appropriate reproductive choices for themselves. These women are grouped together based on the assumption of shared experience, just as the “third world woman” has been discursively produced as a homogenous category (Mohanty 2003) and the “poor” in the United States are assumed to share a culture, an idea that created “an administrative category of policy analysis out of a vast assortment of divided people whose defining characteristic was said to be their subjective sense of powerlessness” (Cruikshank 1999, 77). Reproductive health advocates in India must therefore make choices, “benevolently,” on behalf of these women (Qadeer 1998, 2680). Two groups of women are created through reproductive health care interactions: those who provide reproductive health services, making choices about the reproductive lives of others; and those who accept, demand, or reject these services, who are judged accordingly as proper or improper reproducers.
We can see doctors actively engaged in this process of difference making. I have already shown how many middle class, urban raised doctors seek to mark themselves as separate from the rural and, due to their class position, as maladapted to a rural lifestyle. In addition, doctors separated themselves from their subaltern patients through the use of knowledge – doctors had knowledge of the body and its processes; patients often did not. Doctors knew what “proper” reproduction looked like; patients often did not. As experts, doctors helped to produce a population of patients to be targeted by government health interventions. Escobar argues that, through development discourse, experts created “‘abnormalities’ (such as the “illiterate,” the “underdeveloped,” the “malnourished,” “small farmers,” or “landless peasants”), which [development] would later treat and reform” (1995, 41). Doctors were actively engaged in the process of enlightening their patients who were reproducing ‘incorrectly,’ or not following middle-class advice about hygiene and behavior, thereby participating in the process of producing a ‘known’ population to be the recipient of their health interventions.

Dr. Anju, who works in a government PHC on the outskirts of urban Jaipur, expressed her frustration openly with patients who did not follow family planning guidelines. I sat across from Dr. Anju’s desk one morning as patients filed into the clinic. A pregnant woman sat down on the metal patient stool. Upon discovering that this was the patient’s tenth pregnancy, Dr. Anju turned to me and rolled her eyes. She scolded the woman, saying she was now a high-risk patient because she had been pregnant so many times. “Why have you had so many children?” asked Dr. Anju. The patient’s husband, standing next to her, replied that she had given birth to nine girls, but they had faith that this time it would be a boy. “It’s not a matter of faith!” Dr. Anju replied with frustration. Dr. Anju is not thinking only about population control as she scolds her patient; government population objectives converge in this example with the doctor’s worries about the
health of her patient. We see two very different approaches to family planning in this interaction: the patient’s husband, who is trying hard for a son after his wife has given birth to nine girls, a reasonable calculation in a region with strong son preference; and Dr. Anju, who echoes the public health rhetoric that prioritizes small family size over other concerns. By rolling her eyes conspiratorially at me, Dr. Anju highlights the difference between us, highly educated elite women who “know better,” and the under-educated villagers who insist on trying for a son despite her attempts to persuade them otherwise.

Dr. Asha, who had recently begun working at a small government hospital in Jaipur, told me about an older doctor she works with, Dr. Bela, whom she looks up to as a role model:

Dr. Bela is such a good doctor and cares so much about her patients. She is forever trying to educate them. She has been telling them for sixteen years but they don’t listen! This is what I have learned from her in the one month I’ve been here – that whether they listen or not, we have to keep on telling them. Dr. Bela gets so frustrated with them – she keeps shouting and shouting to make her patients understand. You can see that she’s feeling so much pain on behalf of her patients; she cares so much. Here shouting equals caring. Dr. Bela, as the expert, feels she knows what is best for her patients’ health – and is frustrated when they do not agree (or cannot follow her advice due to structural factors beyond their control). The story of Dr. Bela’s frustration illustrates a fundamental difference between doctors and their government-sector patients: doctors have information and try to give it to patients, but patients are either unwilling or unable to internalize that information. Dr. Asha’s story paints patients as stubbornly holding on to their own ideas about bodies and health while the doctor’s advice rolls off, ignored. For Dr. Asha, Dr. Bela is a good doctor because she does not give up – she continues presenting the same knowledge, over and over for sixteen years, hoping that it will eventually stick. Through Dr. Bela’s perseverance, a population of noncompliant women is produced.
**Doctors as Agents of Empowerment**

The category “women” has been increasingly visible on the international development agenda over the past several decades. The Women in Development (WID) approach to economic growth, arising in the 1970s, advocated for women’s inclusion in the development process, both to help women and to increase the speed of economic development (Rai 2002). This approach, in which “poor women became a sound economic and political investment,” ushered in the era of microcredit lending focusing on poor rural women (Batliwala and Dhanraj 2007:22). The more radical Gender and Development (GAD) approach that followed WID in the 1980s argued for a consideration of the social and political structures that differentially shaped women’s lives, and was more critical of the economic focus of development. This approach proved more difficult to implement in practice as it directly threatened the status quo of gender and power relations, and rejected one-size-fits-all approaches with pre-determined economic endpoints (Rai 2002, Sharma 2008).

GAD approaches envisioned a broad definition of women’s empowerment. But scholars have since shown how the idea of empowerment, when enacted through a neoliberal worldview, shed its radical linkages to political and social restructuring in favor of individualistic self-fashioning (Cruikshank 1999). Sharma (2008), studying a government affiliated NGO active in various Indian states, describes the tightrope NGO workers had to walk as they tried to substantively change the power dynamics that shaped women’s lives while also maintaining the political status quo, which they relied upon for their continued existence. This NGO program sought to empower women by teaching them to make more effective demands on the state. The neoliberal logic that underlies empowerment projects such as this one is that, through education,
one can remake oneself into an empowered subject, thereby reshaping one’s life circumstances.

Sharma describes the neoliberal emphasis on individual responsibility:

Poverty, under neoliberalism, is not understood as a consequence of unequal political-economic and social structures, but as a symptom of improper subjectivity and individual failure…. Furthermore, confronting poverty, powerlessness, and other lacks is not the job of the state, but the duty of individuals who have been properly inculcated in the ways of the market and political institutions and who have the ability to enact their citizenship in a responsible manner” (Sharma 2008, 17-18).

Similar to the many rhetorical projects that define differences between women, empowerment initiatives define those in need of empowerment and those already empowered (Sharma 2008). This discourse is a productive one, creating the very problem its experts are perfectly positioned to solve (Escobar 1995), and producing two groups of women that echo the differences between women created through the female seclusion paradox a century ago. Similarly, it is the very will to empower that creates the “powerless” as a distinctive group (Cruikshank 1999, 71-72).

For example, Bhatt et al. (2010) show the discursive production of difference between women, in this case between the middle-class “new Indian woman” and the subaltern woman. Bhatt et al. (2010) argue that:

the constitution of the new middle class simultaneously depends on the articulation and disarticulation of the subaltern woman, who belongs to the “lower” castes and classes and is typically rural. Specifically, her gendered body serves to affirm development, progress, justice, and agency, rendering the new middle class inclusive and aspirational (p. 130).

Bhat et al. follow diasporic returnees (with various occupations) back to India as they interact with the intimate subaltern, their maids, servants, and drivers. These middle-class employers promote neoliberal techniques of the self to their employees, assuming that it is a lack of education and knowledge that keeps them in their subaltern position. When the employees inevitably fail to control their finances, consumption, and reproductive lives in the model
provided for them, their employers consider these failures to be *individual* failures of character rather than an inability to change the existing power structure. The new middle class is thus marked as inclusive and available to those who bring their behavior in line, but remains closed off in actual practice due to the life circumstances of domestic workers.

As Dr. Anju and Dr. Asha’s statements above show, doctors’ educational approach to health care aligned with the neoliberal ideology of empowerment as they collapsed broad social problems onto the realm of individual behavior. Dr. Anita, a mid-career gynecologist who ran an outpatient clinic out of her home in Jaipur, told me her greatest responsibility to a patient was to “make her aware of what is beneficial to her and what is harmful.” Dr. Anita assumed that the proper behavior would follow from this knowledge, that the patient would be able to shape herself into the right kind of woman engaged in appropriate reproductive behaviors. In Dr. Anita’s view, a patient’s behavior had important social ramifications:

> For nine months the baby stays completely inside the mother; from seven months on the baby’s brain development begins. If you make the patient aware… then the next generation who comes, they will be good. If the mother stays happy during the nine months and takes good nutrition, then afterwards there will be less sickness [in the child]. If the baby stays sick less, then naturally the nation will get a good society, a good population.

Knowledge leads to good behavior; good behavior leads to improvements in society (defined as a “good” (smaller and higher quality) population). Empowerment initiatives seek to facilitate transformations of the type Dr. Anita lays out: from awareness to behavioral change to social change. The root of this social change becomes dependent on individual transformation into a person with the “correct” attitudes and behaviors. Empowered women are expected to understand their rights with regard to the state, including their right to access affordable health care and family planning services. In terms of the state’s reproductive goals, health practitioners are at the front line of this desired transformation. Doctors, along with ANMs and ASHAs to a
lesser degree, are the agents of empowerment (in the form of appropriate health care choices) and development (in the form of reducing population growth and maternal and infant mortality).

**The Contradictions of Empowerment**

The rhetoric of neoliberal empowerment creates a dichotomy between power and powerlessness: you are either empowered, or you are not (Cruikshank 1999, 70). But empowerment is a notoriously slippery target, resistant to empirical measurements and full of middle ground between the binary poles of empowerment and its lack. Often it is women who serve as the bringers of empowerment to other women, working through NGOs or, as in my research, through the government health sector. Pinto’s work in Uttar Pradesh (2008) shows the complexities of the *dai* as a category of birth worker who is forever the object of training but also forever incompletely trained – as such, they are “both objects of blame and agents of change” (p. 218). As experts who are able to deliver empowerment to others, women doctors are assumed to be already-empowered subjects. But they remain marked as women, not able to fit easily into the masculine government health care system that, as I have shown, assumes their unrestricted mobility. Their position in between does not expand the possibilities with which we might think about empowerment, but instead serves to “concretize the two seemingly opposing poles on the empowerment continuum” (Sharma 2008, 62). In other words, doctors, assumed to be already empowered, have only one option – individual failure – when they cannot do what is asked of them in fulfilling a rural posting.

Thinking about women as both objects and agents of development, I turn briefly to the story of Bhanwari Devi, a *sathin* (community worker) from Jaipur district in Rajasthan who participated in the Women’s Development Programme run by the state in partnership with
various NGOs. Bhanwari Devi was part of an initiative training women from disadvantaged backgrounds to spread awareness about women’s issues in their village. When she tried to stop a child marriage involving an infant girl from taking place in 1992, a group of men raped her in retaliation. Because she was already “empowered” through her training, “there was an assumption that the sathin would somehow be able to extricate herself from the prevailing power hierarchies within the village, transcend her subordinate social positioning, and be able to construct networks of solidarity among the women in the village through the creation of women’s groups, which would be her insurance policy against overt aggression…” (Madhok and Rai 2012, 655). Madhok and Rai (2012) argue that those organizing this development scheme did not attend to the potential risks Bhanwari Devi faced for actually attempting to implement the reforms she learned about. Instead, by encouraging disadvantaged women to use grassroots methods to bring change to their villages, the Women’s Development Programme exposed these women to unacknowledged risks and failed to support them after violent retribution. Madhok and Rai argue that any such program must acknowledge the “risks undertaken in the exercise of agency” (2012, 646).

Bhanwari Devi was a member of a Dalit group; doctors come from a diversity of caste positions and differ in their ability to use the social capital that is assumed to come with a medical degree. In terms of class, doctors occupy a position of high social capital with the solidly middle-class salary of a government bureaucrat. The practice of medicine is likewise quite different from that of women’s empowerment work; unlike Bhanwari Devi, the sole directive of doctors is not to stir up conservative social norms. One could certainly argue that the intersections of Bhanwari Devi’s identity create heavier burdens than most doctors are made to bear. Doctors come from families who have prioritized the education of girls; they are likely to
postpone marriage and childbearing for the benefit of their career. Therefore much of the gender discrimination that worries Indian feminists and activists does not apply to doctors. To an overburdened NHM, then, the comparatively slight risks that rural work poses to women doctors do not figure into health planning. Doctors are socially far removed from working-class ANMs, and even farther removed from low-caste traditional birth attendants who are seen as hopelessly steeped in tradition and ignorance (Pinto 2008). Yet, shifting our gaze from sathins to women doctors, we see the same neoliberal worldview shaping women’s empowerment schemes and health care administration. It is assumed that women will be rational actors, free to choose to take their posting or not, or to enter the private sector or not. There is no discussion of the constraints on their choices. There is no acknowledgement of the risk that comes with their work. Women doctors are expected to bear risk individually for the sake of the development of the community.

“In the Government’s Eyes We Are All Equal!”

During a discussion of women’s difficulties in the medical profession, I asked Dr. Mohan, an intern at MGMC, why the government did not consider the social scenario of village life when they attempted to post unmarried women to villages far from their home places. He replied that the government knows about the various dangers to women working in villages, and that certain villages are commonly known to be more dangerous than others. But this knowledge does not sway the administrators in charge of posting doctors. According to Dr. Mohan, “in the government’s eyes we are all equal! So how can the government discriminate?” For Dr. Mohan, the government was able to easily sidestep the “problem” of gender by claiming impartiality. I see the view that emerges from Dr. Mohan’s statement as another way of creating difference
between women. The idea that to acknowledge different needs is to discriminate breaks down entirely when applied to subaltern women. Indeed, the government’s interactions with these women are shaped by the assumption that their difference from men requires intervention.

Sharma (2008) argues that the Indian state is simultaneously and contradictorily produced as masculine (as opposed to feminine NGOs), protective like a father, and nurturing like a mother. The idea that acknowledging women doctors’ problems would lead to preferential treatment is linked to the disappearance of women doctors in the masculine, or unmarked, state. The rural health care system was designed for a male doctor, able to travel and live independently. When women doctors step into the role of Medical Officer, they must work within the same male-gendered system. ANMs and ASHAs face similar difficulties in terms of mobility and living arrangements, but as I have argued earlier, these problems can be acknowledged because the ANM and the ASHA are explicitly female gendered categories. Women doctors become the “nurturing mother” of the state by caring for the female population, but they do not seem to benefit from much of this nurturing care themselves (beyond a stable salary and the perks of government employment). Nor do they experience the protection of the state-as-father, despite the social construction of middle-class women as under constant threat and therefore in need of male protection.

**Conclusion**

In this chapter I have linked the project of difference making inherent in the colonial-era female seclusion paradox to more recent discourses of development and empowerment. Development rhetoric divides women into two distinct categories: those in need of empowerment, and those who (already empowered) deliver empowerment. The health administrator who claimed that lady
doctors don’t have any problems highlighted this difference, as did health literature and official documents that focused on gender as an exclusive “problem” for subaltern women. Women doctors also participated in the project of differentiation between themselves and their patients in the government sector as they presented themselves as knowledgeable experts continually trying to educate their patients.

The government’s attitude toward women doctors hinges on class and educational capital. Women and men, when they are poor or rural, are treated very differently: women are the objects of “uplift” and microcredit schemes, as well as the object of so many public health (most often population control) interventions. But when women are upper-middle-class and highly educated, their difference from men slips away, at least in the eyes of the government. Public health administrators are trained to see a certain constellation of gender and disadvantage, and women doctors existed beyond the confines of the public health gaze. Why would these women at the top of the social ladder need help, or differential treatment? And yet, my research makes it clear that women doctors have different needs from their male counterparts – and this difference, along with the refusal of the state health administration to acknowledge it, helps to explain why there are so many women doctors missing from the rural health care system. The invisibility of these differences leads to silence on the part of the health administration when it comes to solving the problem of rural doctor shortages.

Women doctors, as a result of their class position and educational background, can convey appropriately modern (as opposed to “backwards”) behavior to their patients. But they also bring development to rural areas by their very existence. Women doctors create possibilities for “proper” kinds of interaction with the health care system that cannot exist in male-centric clinical spaces. Therefore, the very presence of women doctors in otherwise underserved rural
areas opens up the potential for the improvement of subaltern women’s health and well-being. Yet, because of the invisibility of women doctors’ problems, and the resulting refusal of rural work by many women, women doctors largely remain failed tools of the state, unable to fulfill the promise of development and empowerment offered by their role.
In this dissertation I have explored the experiences of women doctors as they enter the field of biomedicine, looking in particular at their relationship to rural work and to the structures that produce a statistical shortage of women doctors in village clinics. I have also examined the middle-class feminine protectionism that shapes women doctors’ careers, and connected this to the health of lower-class rural women. In a scenario where doctor-centric institutionalized births dominate, these two issues – middle-class protectionism and lower-class women’s health – are inextricably linked. Ignoring the problems of women doctors ripples throughout women’s health care, with women doctors refusing rural work and women patients facing limited options for care. To shine light on the risks faced by women doctors requires an expansion of the health administration’s field of vision, beyond the poor rural population designated for development efforts, to include the middle-class realm of women doctors.

Throughout the dissertation I have linked the discourse of risk to rural work. Women’s bodies are seen as being at risk whenever they move through public space, be it urban or rural. In general, North Indian cities are not discursively produced as safe spaces for women. And yet, urban-based doctors did not mention safety as a concern when moving around the city for their work. Cities were certainly risky, but doctors were able to manage that risk, primarily by calling upon their social networks. In Chapter 5 Dr. Kavita explicitly distinguished between her easy mobility in her current Jaipur job and her previous difficulties in getting around the village when she worked in a PHC. Urban medical students and doctors had social support in the form of family members, friends, and hostel mates, and they had experience that allowed them to feel comfortable navigating the known risks of the city. The village, in contrast, could be a place of
desolation, a “village of strangers” that the doctor must face alone. If a doctor could be posted in a rural area with her husband, or near family, the sense of desolation and risk dissolved. The reach of a woman’s social network thus emerged as a significant factor in her willingness to accept rural work.

The malleability of the category “woman” is crucial to my argument, in which I show a slippage in the category as it is applied differently to women doctors and the women who are recipients of public health interventions, with very real consequences for both groups. The female seclusion paradox I introduced in Chapter 2, in which women doctors were seen to be the ideal providers of health care for other women because of their assumed similarity – yet must be different enough to escape the rules of gender seclusion that apply to their patients – illustrated this slippage in the colonial period. As I showed in Chapter 6, women doctors are still assumed to be similar enough to their patients to provide the most appropriate care, yet different enough to live outside of restrictions on female mobility. In actual practice, however, women doctors must contend with the umbrella of paternalistic protection that is difficult to stretch to the space of the city. Doctors’ movements are limited in different ways than the movements of lower class women, who are subject to norms of gender segregation that do not usually apply to doctors, but the result is one of restriction nonetheless. It is important to understand exactly how this restriction works for different groups of women, and how they are able to work within (or bend) the rules to fit their needs.

I mentioned in the introduction that one of my motivations for this research was to understand the barriers that kept women doctors out of villages in order to improve the availability of emergency obstetric care. But these chapters have not just been about obstetricians; on the contrary, most of my doctor interviewees worked in primary care. Looking
at rural avoidance as a gendered problem means that any woman doctor’s experiences offer useful insights, as the issues that keep women medical officers and women obstetricians out of rural spaces are intertwined. If we can get more women doctors to feel comfortable in rural areas, and if we can find ways to support them in taking social risks, change can come to rural health care.

**Radical Change**

I see two solutions for the problems I have outlined in this dissertation, one incremental and one revolutionary. Both work toward bringing more women doctors into rural areas. The larger, more revolutionary solution to the shortage of women doctors in rural areas is one that stands outside the purview of government policy and involves nothing short of upheaval to the gendered norms for middle-class women’s mobility, with likely reverberations into other groups of women as well. I find myself compelled to argue over and over that we need to support women doctors in order to improve health care for poor women, as if this move is necessary in order to justify their support. It probably is necessary to convince public health officials to take notice of the problems I have highlighted in this dissertation. But framing the problem in such a way only perpetuates the assumption that middle-class women’s concerns are not in and of themselves important, given the comfortable state of their lives. Most of the doctors I met did not need to work in order to survive; they (mostly) hailed from comfortably middle-class families and married into families with one or more working men. But addressing restrictions on access to public space, along with the paternalistic restrictions on women’s movements, will help many groups of people in Rajasthan. The lives of middle-class urban women and lower-class rural women are linked in that re-envisioning public space can impact both. My dissertation furthers Phadke’s (2013) project to make public space available to all in India. According to Phadke, “the question of
making streets safer for women is not an easy one, because the discourse of safety is not an inclusive one and tends to divide people into ‘us’ and ‘them’ tacitly sanctioning violence against ‘them’ in order to protect ‘us’” (2013, 50). Phadke rejects the idea that cities can only be safe for middle-class women by removing “undesirable others.” To counter this idea, Phadke et al. (2011) propose a radical program of loitering in the city:

We make a case for loitering as a fundamental act of claiming public space and ultimately, a more inclusive citizenship. We believe the right to loiter has the potential to change the terms of negotiation in city public spaces and creating the possibility of a radically altered city, not just for women, but for everyone…. For women, such a space of ambiguity can be powerful. Since the very act of being in public without purpose is seen as unfeminine, loitering fundamentally subverts the performance of gender roles. It thwarts societal expectations and enables new ways of imagining our bodies in relation to public space. (p. 177-179).

For Phadke and her colleagues, women’s mobility can only increase if public space is opened to more people – rather than ousting those deemed threatening to “respectable” women’s sexual purity. Further, they connect the performance of loitering with the potential recalibration of the meanings of women’s sexual purity and the rules around its protection. For Phadke and her colleagues, women loitering will do something; this action can have a transformative effect. Women across India have taken up the challenge to inhabit public space subversively, as seen in the #WhyLoiter campaign, in which women post photos of themselves conspicuously enjoying themselves in public spaces, and the #IWillGoOut protests of January 2017, in which women in thirty Indian cities marched to assert their right to public space (Phadke and Roy 2017). Another noteworthy movement is Blank Noise, working on the issues of sexual assault and victim-blaming and similarly focused on women’s rights in the public sphere.82

How might reimagining urban public space affect urban middle-class women’s ability to live successfully in villages? Villages were not inherently more dangerous than cities; both spaces contained people who were seen as threats to women’s respectability. Both spaces also
contained the potential for sexual violence. In women’s stories of mobility, the difficulty came from maintaining (and proving) one’s sexual purity outside one’s social network. If women are able to remove this requirement – to move freely through urban space without the demands placed on “respectable” women, perhaps through loitering as Phadke et al. (2011) propose – it would, in theory, change women’s relationship to space no matter where they are.

Another issue that may require radical change addresses the most common complaint from women doctors who have settled in villages for a number of years, but still seek to return to the city: a lack of educational opportunities for their children. Doctor mothers send their school-age children to urban schools, not rural schools, which are not seen as adequate preparation for a professional career. Working in a village requires mothers to live separately from their children and to surrender some of the responsibilities of a “good” mother. Doctors presented urban education for their children as non-negotiable; even Dr. Varsha, the health administrator who felt nostalgic about the kind of life she could have had with her children in a village, kept them in the city for schooling. The Rajasthani government has taken this problem seriously and since 2015 has offered extra days of leave as part of their maternity benefits for mothers to use at any point while their children are under age 18. This ruling was an answer to women’s demands to be home with their children during exam times, and is likely to offer them some relief. The new rule is not a complete solution to the problem of parent-child separation, however. It only applies to mothers, reinforcing the idea that women are best suited to guide their children’s education. (In practice I have seen many fathers take active roles in their children’s lives and education in Jaipur, but the responsibility for success, and blame for failure, rests on the mother’s shoulders.) The maternal leave policy also cannot solve the problem of long-term parent-child separation, one that frustrated many parents working in villages. Again this is an issue that reaches far
beyond the health administration’s purview; they cannot easily change the cultural divide
between urban and rural, or the idea that urban education is inherently better. Even if the
government were to sink resources into rural education, the perception of its inadequacy would
be difficult to change.

**Incremental Change**

A less radical solution is to bring women’s problems to the forefront of policy making; to have
the government at the very least *acknowledge* that women doctors have particular problems that
are not currently being addressed. This acknowledgment opens the possibility for policy changes
that can address some of the problems women doctors have expressed. One could be a greater
emphasis on posting wife-husband doctor couples together in the same area, if they request it.
Based on my research, women have a better chance of succeeding in long-term rural work if they
are posted in the vicinity of their husbands. This is already a stated goal of the health
administration but works somewhat haphazardly in practice. Some areas do not have positions
available for more than one doctor. Doctors also get swept up in the politics of transfers with
results that are not always in the best interests of doctor couples, such as when Dr. Meenakshi’s
husband was transferred away from Devipura CHC where they both worked. This was not a
catastrophic move for Dr. Meenakshi, as there were other women doctors at the CHC, and by the
time of this transfer Dr. Meenakshi had been long settled in Devipura. But were this a more
remote location, or Dr. Meenakshi the only woman at the clinic, she would have had a more
difficult calculation of risk to make.

Second, I seek a solution that does not reinforce compulsory heterosexuality, allowing
unmarried women to succeed in rural postings even without the social advantages of their
married women colleagues. Unmarried women who live away from their families in cities find
security in other women, residing in women’s hostels for students or professionals. Women medical students similarly find safety in each other as they travel the city in pairs or groups. This type of security could be created on a much smaller scale in villages. The state could ensure that there are multiple women (other medical officers or staff members) posted at a particular site, especially for PHCs, creating more opportunity for women to find living arrangements together. In addition, medical colleges could sponsor successful village returnees to speak to students about the steps they took to feel safe away from their family (living with village residents, commuting, etc.) so that students develop a more nuanced vision of what rural work could look like, rather than a blanket dismissal of all rural work as unsafe.

Doctors are not unique in their hesitance to move from city to village. Fagernas and Pelkonen (2012) found that many public-sector teachers, particularly women from urban backgrounds, were reluctant to take remote postings. Like Dr. Nandini who commuted from Jaipur to Krishnapura PHC, teachers often do the daily “up-down,” as it is referred to in English, between more urban homes and more remote schools. Unsurprisingly, this was connected to high rates of absenteeism. Teachers, whose minimum requirement is a bachelor’s degree (although many have master’s degrees), face the same type of social barriers and the same environment of risk that makes moving to a remote, unknown place challenging. But the presence of teachers and other government workers also present the possibility of creating a critical mass of “like-minded,” urban-educated women in rural settings. Importantly, doctors did not mention teachers, other government employees, or NGO workers when talking about their social lives in the village. But expanding questions about risk and rural avoidance to other sectors of government employment would be a fruitful avenue for further research.
Some working in public health have advocated for a new medical degree to address the problem of rural doctor retention, the Bachelor of Science (BSc) in Community Health. Those holding this degree would only be eligible to practice in rural areas. The degree would take three years (instead of the five years of an MBBS) and cover basic anatomy, normal deliveries, perinatal care, vaccination, and the treatment of diarrheal diseases, pneumonia, tuberculosis, fevers, and skin infections (Dhar 2013). The BSc in Community Health has been proposed and promptly rejected by the Medical Council of India (MCI) many times and in many forms over the last few decades (Gautham and Shyamprasad 2010). At the time of my research, this degree had finally been approved by the MCI but was left to the individual states to take up; it was not available in Rajasthan. Doctors, fiercely protecting their professional niche, were quick to weigh in on the BSc in Community Health in the press. Doctors claimed this degree would create “half-baked” practitioners (Garg et al. 2011) or an “army of quacks” (Rathee 2013). One doctor worried that graduates of this program would become “slaves” with a degree that would only allow them to live and work in rural areas (Rathee 2013). Medical officers are justified in worrying about a potential threat to their professional domain, because while the training for an MBBS and a BSc in Community Health are different, in practice the two types of practitioners would do very similar work. And yet, as I have shown, the structure of MBBS education, as well as the risk to women in rural work, have kept doctors out of rural spaces. This degree in some ways represents an admission of defeat: we will never get MBBS doctors to work in villages, so we should try someone else. The solution also pragmatically accepts the class-based problems inherent in coaxing urban-educated doctors into village spaces while it perpetuates the idea that only some kinds of people are suited to live in villages. If Rajasthan implements this program, it may very well bring more trained medical practitioners into village clinics, but not without reifying the
divide between urban and rural and the differences between the kinds of people who inhabit both spaces.

**Individual Problems**

Currently the issues women doctors face while working in a village are seen as individual problems rather than structural problems. Doctors are left to figure out individually tailored solutions to the challenges posed by rural work. Doctors have come together in groups to protest violence from patients at tertiary hospitals, quotas for medical education and government jobs, and the rural medical degree. There has been no group protest to demand better work conditions specifically for women – perhaps because there is no clear and easy solution to the problems I have outlined in my dissertation. India has a rich history of protests and strikes that includes a wide range of gender issues (Kumar 1993), but before a protest can coalesce the issue needs to be on the population’s radar. While women doctors’ avoidance of rural spaces continues to be seen as an individual problem, larger pushback is unlikely.

Health officials see a very different problem from the one I see. For me, the problem of rural doctor retention is both narrower, with risks specific to women that go unnoticed by the government, and broader, affecting far more middle-class women than doctors. I can give policy recommendations, but how can health policy fix social restrictions on women’s movement, or the idea that women’s sexual purity needs to be protected by male relatives? Pigg (2013) gets to the heart of this dilemma when she argues for the benefits of “sitting” rather than “doing” in public health research. While those involved in public health “do” things, ethnographers are accused of simply sitting around, observing and thinking. In other words, ethnography produces knowledge that, through a public health lens, “merely drag[s] confident, useful action down into
a mire of doubt and criticism” – and yet, according to Pigg, is crucially important for understanding lives and health care (p. 128). Through ethnographic research, the act of sitting with and following doctors across geographic distances and between work and home, I have produced knowledge about women doctors that does not appear on quantitative public health surveys – it is untidy knowledge, without easy solutions, and threatening knowledge, that risks upsetting the status quo of gender relations. It is difficult to condense the issue of women’s mobility into actionable bullet points, and difficult to translate my results into language that makes sense given current understandings of gender in development and public health. It is also too much to ask health policy to fix problems of women’s mobility. At the same time, the incremental changes I have outlined above are only patches to a larger problem. If we can link the mobility of women doctors to the problem of marginalized women’s reproductive health, the government might be more willing to take an interest than if the problem of rural avoidance remains an individualized one for middle-class women with elite professional status.
1 Even in the comparatively un-gender-segregated social world of the United States, many women prefer to see a woman OB/GYN (Karlamangla 2018).

2 Donner’s (2008) ethnography of middle-class women in Calcutta demonstrates the very different concerns of those who are able to give birth in private nursing homes that offer more services and more luxury than the public health care system.

3 As Pinto (2008) shows, the distinction between “doctor” and “midwife” or “post-partum worker” is far from clear. The practitioners she studied made use of different tools and symbols of biomedicine and had varying levels of “official” biomedical training.

4 The same is not true for nurses and other hospital staff – reprimands coming from these people are seen by the birthing women as abuse (Van Hollen 2003). Nurses add another important dynamic to the power relations of the hospital that is worth considering.

5 My use of the term “doctor” here refers to those with professional degrees. Hijras are likely to find discrimination in professional medical spaces and turn instead to those labeled “quacks” (Kar and Moulak n.d.). Reddy (2005a) found that hijras in Hyderabad preferred to visit a clinic for men who have sex with men (MSM) established by a gay activist, but were asked to come only on Saturdays because their presence was deemed shameful. A hospital in Puducherry in South India recently instituted a “gender care team” to provide respectful care to transgender patients (this was unusual enough to reach the national news). This initiative was led by an anesthetist who was herself transgender; she had received her medical degrees while identifying as a man and transitioned in her thirties (Ratnam 2018).

6 Although other corporate hospitals have opened in Jaipur over the last few decades, boasting shining new highrise buildings and fancy websites, my informants still spoke of SMS as the best hospital in the state.

7 I have not used a pseudonym for MGMC or SMS. Because there were only two medical colleges in the city at the time of my research, these two institutions would be instantly recognizable based on their description. All other names of hospitals and villages are pseudonyms.

8 Biomedicine exists in India among many other healing systems. These other systems tend to go in and out of vogue in state health policy but remain widely available and widely used by the population. They also tend to be the focus of anthropological studies of medical practitioners in South Asia (Langford 2004, Cameron 2010, Flueckiger 2006, Pinto 2008, Kakar 1982).

9 Many critical medical anthropologists reject the common claim made by governments and international funding organizations that health care is “too expensive” for some countries, instead arguing that we need to reorient our relationship to health care to see it as a basic human right, and overcome economic inequalities that keep health and health care out of the hands of many (Farmer 1999, Baer et al. 2003).

10 See Sharma 2008 for an example from the realm of women’s empowerment.

11 Government spending on health care was 1.3% of GDP in 2013 (http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS).
It is dangerous to generalize too much about health care facilities across the country: some states have managed great feats in the public sector while others struggle. The northern Hindi belt that encompasses Rajasthan usually lags behind in health indicators. But all is not always rosy in the south either – see Smith 2009 for an illustrative case study comparing maternal mortality in Karnataka and Tamil Nadu, two southern states with similar socio-economic profiles but different health outcomes.

See Inhorn (2006) for a discussion of the many meanings of “women’s health.”

Selective abortion, which allows a family to select for a son without having too many children, is illegal but still happens regularly. This problem is greatest in cities where people have the means and access to buy fetal sex knowledge from their doctors (Kaur 2007).

Vaginal infections, particularly those associated with sexually-transmitted infections, are beginning to receive more attention on the global health scene (Low et al. 2006).

“Madam” is often appended to a person’s name as a sign of respect. Professors at the medical college were also addressed using their first name followed by “madam.”

At the time of my research, women received Rs. 1000 in urban areas and Rs. 1400 in rural areas.

At the time of my research, an ASHA received Rs. 300 for “motivating” a woman to get prenatal care and another Rs. 300 for “motivating” an institutional delivery.

AYUSH, an acronym used in India to encompass professionalized non-biomedical healing systems (Ayurveda, yoga, unani, siddha, and homeopathy), is also officially supported by the government, and Ayurvedic, Unani, and Homeopathic doctors could occasionally be found at Primary Health Centers in rural Rajasthan. Despite the ubiquity of these medical systems, however, they remain ancillary to biomedical care when it comes to reproductive health. AYUSH has received more support quite recently under Prime Minister Narendra Modi (The Hindu 2017).

This is not just a problem for India. One study compiled absentee information from Bangladesh, Ecuador, India, Indonesia, Peru, and Uganda, finding that, on average, 35% of health workers were absent from their posts (Chaudhury et al. 2006).

This reason was only one of many, and patients actually mentioned it less than other reasons, including: the expense of traveling, bad road conditions, health staff attitudes, lack of time, and lack of permission. Clearly the lack of women doctors is not the only problem plaguing women’s health in Rajasthan. Still, the fact that fifty percent of respondents mentioned that their preference for a lady doctor was a factor in ignoring a referral makes it significant enough to warrant attention.

Men may feel similarly shy about approaching a woman doctor for intimate concerns, but the ratio of male to female doctors is so skewed in favor of men that, except in the most remote areas, men can find a male doctor in the vicinity even if their closest PHC is run by a woman. Studies have not been done in other states to provide a means of comparison.

Zenana refers to an area of the house reserved for women.

In reality, this was rarely the case. Traditions of gender segregation were present only in some areas of the country (mainly the north and east) and in some groups (such as Muslims and
Rajputs). Even where this tradition did exist, most families could not afford to have women be completely segregated.

26 Doctors also came to India from the United States, but their presence in India is not evidence for a lack of opportunities in their own country.

27 Doctors, in contrast, have historically come from so-called forward castes. This is rapidly changing as affirmative action reserves half of all seats in medical colleges for those from historically marginalized castes. For further discussion of caste in medicine see Chapter 3 on medical education.

28 Joshee implies that it was more acceptable for Christian and Brahmo women to attend school.

29 Data from the more recent 2011 census trickles out at a slow pace; as of this writing, data on occupation by gender is not yet available.

30 Annual Status of Higher Education of States and UTs, India, 2013. From www.wbeducom.in; accessed 2/12/16.


32 https://www.mciindia.org; accessed January 13, 2012. According to the Medical Council of India, as of May 2018 the number of seats in Indian medical colleges has increased to 61,390.


34 Zigon’s interpretation of ethics and morals is different from that of many anthropologists, for example Kleinman (1995) who describes ethics as “a codified body of abstract knowledge held by experts about “the good” and ways to realize it,” while morals are “the commitments of social participants in a local world about what is at stake in everyday experience” (p. 45). Kleinman sees evidence of the moral everywhere, in “the local politics of interpersonal relations,” while Zigon sees it only in particular instances of breakdown. I see this difference as a matter of degree; both theorists find something interesting in situations where people must work through what it means to be a good person, with Kleinman casting a wider net in designating situations that involve moral work.

35 In theory, any woman could take advantage of free delivery, but based on my own observations and conversations with the staff, the general ward was mostly filled with women of lower economic status living on the outskirts of Jaipur city.

36 http://www.mgmch.org/services-facilities; accessed March 7, 2017. Doctors told me that medical services are the same for all patients in the hospital regardless of the differences in room amenities.

37 SMS hospital in Jaipur also has a range of room amenities that can be purchased. A bed in the “AC Cottage Ward” costs Rs. 1,600 ($23) per day. Rural primary care facilities do not have the same fee-based levels. https://timesofindia.indiatimes.com/city/jaipur/Cottage-ward-and-ICU-rates-hiked/articleshow/44831126.cms; accessed May 24, 2018.

38 Mahatma Gandhi Medical College “Clinical Material: August 2013 to July 2014.” http://www.mgmch.org/assets/files/19 %20Clinical%20Material%20in%20the%20Hospital(1).pdf; accessed 4/7/17. The head nurse of the general obstetrics ward told me they had an average of seven to eight deliveries per day under her jurisdiction (outside of the private wards).
Based on 2014 exchange rate.

Lakhs and crores are common Indian numbers. One lakh = 100,000; one crore = 10,000,000.

Unlike the situation in the United States, government colleges, in general, are more prestigious than private colleges in India.

In 1994, the central government had implemented reservations for OBCs in government employment but did not extend them to higher education for fear of protests.

Quotas and percentages are subject to political contestation and have made a slow but steady creep upwards (it is easier politically to add more quotas on than to take away a group’s quota). The state government has control over how the quotas are distributed across the various groups, and also has the ability to determine which caste groups will fall under the OBC category. After years of protests by the Gujjar caste group in Rajasthan (often turning violent), in 2017 the state government included the Gujjar caste (along with four other groups) into the OBC group. Other OBC caste groups protested this move, fearing it would take quota allotment away from them. To solve the problem the government raised the OBC quota from twenty one percent to twenty six percent, in violation of a Supreme Court guideline that the total quota seats not exceed fifty percent. Rajasthan’s decision will most likely be contested in court. [http://www.newindianexpress.com/nation/2017/dec/22/rajasthan-government-approves-1-per-cent-reservation-for-gujjars-1733957.html; accessed 6/1/18.]

American women, of course, have not experienced the United States as a place free from sexual harassment, as has been increasingly evident during the #MeToo movement. See also Cassell (1998) on the challenges women surgeons have faced in the US.

Parental control over children’s schooling and career decisions happens for less prestigious professions as well.

Some students – especially those graduating from the top medical colleges – leave to begin careers in other countries, much to the anxiety of those who feel that this “brain drain” robs the nation of its brightest minds (Mullan 2005, Lahariya 2007). Not many of my interviewees were planning to take this route, in contrast to Ruddock’s (2017) research with AIIMS students.

I have used the real names of Dr. Punit of Health Oasis and Dr. Punia, principal of MGMC, in this section.

Below-wale is a creative English-Hindi mix, using the Hindi suffix wala (pl. wale) that means “one who does” or “one who is associated with.”

“Feeling superior” in Indian English does not carry the connotation of shameless immodesty that it would be likely to convey in American English.

Biomedicine may dominate official health discourse, but, as Van Hollen argues, biomedicine is not hegemonic – “it is not taken for granted as the only naturally legitimate form of care” (Van Hollen 2003, 15). Practitioners of other medical systems, such as Ayurveda, have launched their own critiques of biomedicine as inappropriate for Indian bodies (Langford 2002).


In India the designations for cities are well defined, while the “rural” label is applied to everything that falls outside of the urban category. The criteria for “urban” are: 1) all places having urban-designated municipal bodies; and 2) all places with a population greater than
5,000, a population density of 400 people per kilometer, and seventy-five percent of the workforce (male only) employed in non-agricultural labor (Bhagat 2005, 63).

53 Prior to the 1950s, most anthropological studies conducted by foreigners in India focused on tribal groups (Béteille 1991, 4). In Indian institutions, anthropological research continues to be dominated by tribal studies while sociology takes on the rest of Indian society.

54 According to a World Bank estimate, India’s rural population was sixty-seven percent in 2016 (this is based on 2011 census data, which listed India’s rural population at nearly sixty-nine percent, but steadily decreasing). https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS; accessed May 23, 2018.

55 This statement is an imperfect distillation of a vast body of writings produced by these three people. Yet, for my purpose here, it is most important to consider what part of their discourse on the village, necessarily simplified, has remained to influence understandings of rural space today.

56 Panchayat raj refers to a system of decentralized government based on local assemblies common to South Asia.

57 The Rajasthan Medical Services Corporation (RMSC) purchases and distributes generic drugs from an “essential” drug list. They give their business to whoever can produce the drugs most cheaply (although they do claim to perform rigorous quality testing of the final product). See http://www.rmsc.nic.in/Drug_Procurement.html; accessed 3/10/16.

58 India is no different than other resource-poor health settings where doctors must make do with whatever supplies they can get (Livingston 2012, Street 2014, Wendland 2010).

59 The starting salary for a medical officer in Rajasthan in 2011 was approximately Rs. 30,000 ($440) per month (http://daily.bhaskar.com/news/RAJ-JPR-docs-paid-more-than-bureaucrats-in-rajasthan-2688902.html; accessed 2/10/17). Government salaries provide a standardized base pay with extra allowances added depending on circumstance, such as a dearness allowance that accounts for inflation and a housing allowance added for doctors living outside of major cities. The base pay range for medical officers during my research period was Rs. 15,600 (for a new hire) to Rs. 39,100 (for a senior doctor) (http://finance.rajasthan.gov.in/aspxfiles/sixthpaycommission.aspx; accessed May 24, 2018).

60 A district in Rajasthan.

61 See also Chatterjee (1993), who does not write specifically about adivasis, but outlines the ways in which middle-class, upper-caste women distinguished their sexually pure selves from an imagined “common” woman, “who was coarse, vulgar, loud, quarrelsome, devoid of superior moral sense, sexually promiscuous, [and] subjected to brutal physical oppression by males” (p. 127).

62 See also Gilbertson (2014) on the balance middle-class women in Hyderabad must strike between being respectable and “fashionable,” which often includes clothing that reveals more skin. Van Wessel (2011) similarly charts youth fashion and new, “broadminded” and “forward” ways of thinking in Baroda, Gujarat.

63 Blaming the doctor for a patient’s death is not unique to India; the same happens in the US, although the patient’s family is more likely to respond with litigation rather than physical violence.

64 https://www.youtube.com/watch?v=vwW0X9f0mME; accessed May 24, 2018.
It is possible that Dr. Nisha and Dr. Madhu did have negative experiences in the village but were unwilling to share their stories with me. Another doctor, Dr. Divya, made it clear that something had happened but would not share exactly what. Yet their insistence on labeling the village “dangerous,” even without narrating actual stories of harassment or assault, contributes to the discourse of the risky village.

This survey was conducted in 2015-2016 and was the closest survey to my fieldwork period (the previous survey took place in 2005-2006).

The two states in which less than twenty-five percent of women had this mobility were in the South (Kerala at twelve percent and Lakshwadeep at eight percent), a finding that surprised me based on stories circulating in the North that tell of Southern women’s greater mobility. According to this survey, the greatest mobility was found in the Northeastern states of Mizoram and Sikkim.

See also Beck (1992) on the emergence of “risk society,” characterized by broad ecological and technological risk.

Kumar (1993) tracks protests against police officers, landlords, and employers raping women over the 1970s and 1980s.

Niranjana and Vasudevan (2016) point out that the entire debate about access to public space is framed within the middle class where it is assumed that women reside in a separate, private, domestic space. Women living in slums or on the street experience no such distinction between private and public space.

Blaming women for sexual violence that men commit against them is not unique to India; this is common in the US public sphere as well.

The Indian National Crime Records Bureau reported that eighty-six percent of rapes in India are committed by someone known to the victim: close family members, neighbors, employers, etc. (Bhalla 2015).

In other contexts, particularly for Muslim women, purdah has been linked to an experience of piety; through the bodily practice of covering one’s head and/or face, a woman can cultivate piety (Mahmood 2005).

Many medical students used two-wheelers to get around the city, but they were not seen as being suited for long-distance travel between city and village.

The United States is no stranger to this kind of racial/ethnic/religious profiling. Dominant American culture has written risk on the bodies of Black men (as criminals-to-be) and Muslim men (as terrorists-to-be).

Men engaging in time-pass are not only a threat to middle-class outsiders. Jeffrey et al. (2007) found that Chamars (an SC caste) congregating in the space of a village was seen as a threat to other village women and girls.

See GOI 2014 for a complete list of health manpower statistics tracked by the NHM in their yearly progress reports.

FHWs include ANMs and ASHAs but not nurses or doctors.

Economic and Political Weekly is a multi-disciplinary English language publication with a vast reach among Indian scholars. The journal often publishes research and commentaries on public health and gender studies.
India is not alone here; the social world that contributes to poor health is conspicuously missing in biomedicine as a whole, as biomedical knowledge about the body excludes social context by design. See, for example, Good and Good’s (1993) study of medical training at Harvard.

See also Van Hollen (2003), where doctors’ threats of abuse are often seen by patients as “maternal gestures” (p.133).


Van Hollen (2003) found a similar distinction between professionally trained doctors and nurses, brought in from outside, and dais, or midwives, recruited from a local population and trained in allopathic hygiene techniques from the colonial period onwards. Initially the dais were seen as a stop-gap measure, “while the long-term goals lay in the development of a cadre of professionally trained women doctors, nurses, and even midwives who would oversee deliveries in hospitals” (Van Hollen 2003, 53). The new rural degree is evidence of a return to the idea that, in the absence of professionally trained outsiders, specially trained locals are the next best option.
APPENDIX I: LIST OF ACRONYMS

AIIMS: All-India Institute of Medical Sciences (Delhi)
ANM: Auxiliary Nurse Midwife
ASHA: Accredited Social Health Activist
AYUSH: Ayurveda, Yoga, Unani, Siddha, and Homeopathy (government ministry for non-biomedical healing systems)
CEHAT: The Centre for Enquiry into Health and Allied Themes
CHC: Community Health Center
FHW: Female Health Worker
GOI: Government of India
MBBS: Bachelor of Medicine, Bachelor of Science (basic health degree in India)
MCI: Medical Council of India
MD: Medical Doctor (advanced health degree in India)
MGMC: Mahatma Gandhi Medical College, Jaipur
NHM: National Health Mission
OBC: Other Backward Classes
PG: Post-Graduate
PHC: Primary Health Center
RTC: Rural Training Center (part of MGMC)
SC: Scheduled Caste
SC: Sub-Center (small local unit connected to a PHC)
SMS: Sawai Man Singh Medical College, Jaipur
ST: Scheduled Tribe
UTC: Urban Training Center (part of MGMC)
WMS: Women’s Medical Service of India
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## BIOGRAPHICAL DATA

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### Education

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<td>December 2018</td>
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<td>Smith College (Art History)</td>
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### Areas of Specialization

Cultural anthropology; medical anthropology; gender; cultures of South Asia; public health; women’s health; medical education; space/place

### Publications – Peer Reviewed


### Presentations

- “Purdah by the Dashboard Light: Cars, Protection, and Care for the Female Body.” Annual Conference on South Asia, University of Wisconsin, Madison. 2016
- “Improvising the “Up-Down Life”: Young Women Doctors in Rural Rajasthan, India.” Annual Conference on South Asia, University of Wisconsin, Madison. 2014
- “A Lady Doctor for the 21st Century: Women in Delhi Medical Schools,” Syracuse University South Asia Center, March 8. 2011
Teaching Experience

San Diego State University, Instructor 2016-present
Courses taught:
ASIAN 101, Asian Thought and Cultures
ANTH 303, Principles of Sociocultural Anthropology
ANTH 508, Medical Anthropology
ANTH 520, Ethnographic Field Methods
ANTH 536, Gender and Human Sexuality
ANTH 537, Anthropology of Childhood

University of San Diego, Instructor 2017-present
Courses taught:
ANTH 494, Gender and Human Sexuality
ANTH 494, Medical Anthropology
ANTH 494, Childhood in Cross-Cultural Perspective

Barnard College Pre-College Program, Instructor Summer 2016
Courses taught:
Issues in Women’s Health

Syracuse University, Teaching Assistant 2010-2011
Courses taught:
ANT 131: Introduction to Biological Anthropology
ANT 185: Global Encounters (writing intensive)

Awards and Honors

FLAS Fellowship for Dissertation Research 2017
Society for Medical Anthropology Student Travel Award 2014
FLAS Fellowship for Dissertation Research, Rajasthan, India 2013-2014
American Institute of Indian Studies Language Fellowship 2012-2013
Outstanding Teaching Assistant of the Year, Syracuse Graduate School 2012
Maxwell School of Citizenship Dean’s Summer Fellowship Summer 2011
Moynihan Institute of Global Affairs Goekjian Summer Research Grant Summer 2010
Bharati Memorial Fund grant for pre-dissertation research Summer 2010
FLAS Fellowship, Hindi (Syracuse University) 2009-2010
FLAS Fellowship, Hindi (Syracuse University) 2008-2009
FLAS Fellowship, Hindi (Jaipur, India) Summer 2008
**Overseas Research and Language Experience**

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**Academic Service**

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**Professional Memberships**

- American Anthropological Association
- Society for Medical Anthropology
- Council on the Anthropology of Reproduction
- Health Systems Global – Social Science Working Group