

A Doctor in the House:  
Balancing Work and Care in the Life of Women Doctors in Pakistan

by

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## ABSTRACT

Under-representation of women doctors in medical work force despite their overwhelming majority in medical schools is an intriguing social issue for Pakistan raising important questions related to evolving gender relations in Pakistani society. Previous research on the broader issue of underrepresentation of women in science has focused primarily on the structural barriers to women's advancement. It does not account for the underlying subtle (and changing) gendered power relations that permeate everyday life and which can constrain (or enable) the choices of women. It also does not address how women are not simply constructed as subjects within intersecting power relations, but actively construct meaning in relation to them. It raises interesting questions about the cultural shaping of subjectivities, identities and agency of women within the web of power relations in a society such as Pakistan.

To analyze the underlying dynamics of this issue, this dissertation empirically examines the individual, institutional and social factors which enable or affect the career choices of Pakistani women doctors. Based on the ethnographic data obtained from in-depth, person centered, open ended interviews with sixty women doctors and their families, as well as policy makers and the stake holders in medical education and health administration in Lahore, Pakistan this dissertation seeks to address the complex issues of empowerment and agency in the context of Pakistani women, both in individual and collective sense.

Participation in medical education is ostensibly an empowering act, but dissecting the social relations in which this decision takes place reveals that becoming a doctor

actually enmeshes women further in the disciplinary relations within their families and society. Similarly, the medical workplaces of Pakistan are marked by entrenched gendered hierarchies constraining women's access to resources and their progression through medical career. Finally, the political implications of defining work in medicine, and devaluing care in capitalist economies is explored.

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## PROLOGUE

### PRESENTING THE CASE OF WOMEN DOCTORS IN PAKISTAN

September is a stressful month for many Pakistani households. It is the time when results of admission tests for medical colleges are announced. Students and parents flock outside the medical colleges where lists of students to be admitted in the following session are displayed. In 2016, according to news reports, more than fifty thousand students (approximately seventy percent of whom were women) applied against 3400 available positions in public and private medical colleges in Punjab alone (Pakistan Today 2016; Dawn 2016). Last year the students needed more than 82 percent points (calculated from a formula that takes in account the results of two years of intermediate examinations and medical college entry test) just to be eligible for application. For those who make “the list”, there is no greater honor. Once successful candidates are announced, a flurry of social activity follows. Parties and gatherings are arranged and gifts are exchanged in the honor of those who made it to medical college. If you are a Pakistani student who made it to medical college, you will never forget the exhilarating feeling of pride and joy that came from seeing your name on the list of successful candidates.

For past decade or so, it is the women students who have dominated the admissions in medical colleges in Pakistan. This trend is paradoxical to other science, technology, engineering and mathematics (STEM) fields where men consistently outnumber women at all levels of education, in STEM careers and in administrative positions. As data collected by the Pakistan Council of Science and Technology indicates, there is a persistent gap in income, research productivity, recognition, and resource

allocation between men and women scientists.<sup>1</sup> In contrast, the number of women students in medical colleges, however, has been increasing consistently, and in most medical colleges, both public and private, women now far outnumber men. Since the inception of Pakistan, the number of women students in medical colleges was limited by a gender based quota imposed by the Government of Pakistan to a maximum of twenty percent. As the number of women applicants grew however, many women students were denied admission even when they had better scores than men students. In 1990, the Supreme Court of Pakistan deemed this quota unconstitutional and discriminatory, noting that as per the Constitution of Pakistan, “no distinction can be made on the basis of sex alone” and hence stipulating solely merit based admissions. Since then, the number of women graduating from medical colleges has increased dramatically from 20 percent in 1990 to over 80 percent in 2015 (Pakistan Medical and Dental Council 2015). Although this is an indication of evolving roles of women in the highly conservative society of Pakistan, there remain obstacles: Unfortunately, this increase in number of medical graduates has not translated to a concomitant increase in the number of working women health practitioners (Arif 2011) as most of the women who graduate do not go on to actually practice medicine. Statistics from Pakistan Medical and Dental Council (PM&DC)<sup>2</sup> provide some evidence of this marked disparity: Even though more than 80% of graduates from medical colleges are women, only 45% of them are registered to

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<sup>1</sup> These finding can be accessed at Pakistan Council of Science and Technology’s website [www.pcst.org.pk](http://www.pcst.org.pk)

<sup>2</sup> The regulatory and registering authority of medical students and practitioners in Pakistan

practice medicine and only 27% complete a post-graduation degree as specialists. In addition, the few women practicing physicians remain restricted to certain “female appropriate” specialties (Huda and Yousuf 2006). Since medical education is highly subsidized by the government in Pakistan, the “leakage” of these women represents a significant loss, raising concerns for the health system of the country.

In 2014, PM&DC created further controversy by reintroducing the gender based quota in their admission policy to limit the number of women medical students to 50%. In their notification PM&DC stated that increasing number of women students in medical colleges, coupled with the trend that majority of them did not practice at all or left their profession, has contributed to severe shortage of medical professionals in Pakistan. This led the council to decide that at least half of the seats should be reserved for men students who are more likely to continue practicing as doctors. This policy was immediately challenged in the High Court of Punjab for being discriminatory against women students who, despite being of higher merit, would be denied admission based on this policy. In response, PM&DC cited a study carried out by Dr. Shaista Faisal, an official of PM&DC, in support of their decision which showed that the majority of women doctors faced difficulties in balancing their domestic responsibilities with their work, and as a result, few of them pursued their career.<sup>3</sup> The High Court, in its decision<sup>4</sup> agreed with PM&DC about the problems faced by the resource-scarce health economy of Pakistan, but decided

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<sup>3</sup> Other than the High Court decision cited above, I have found no other mention of this study, nor has its findings been published anywhere. I did managed to communicate with the researcher, Dr. Shaista Faisal, about the particulars of the study. She confirmed the findings presented in court and that its data or any results are yet to be published.

<sup>4</sup> W.P. No 28142 of 2014 Asma Javaid, etc., Vs. Government of Punjab, etc.

that the quota based admission policy was unconstitutional and discriminatory. The court also stressed that instead of restricting women students' access to medical education, PM&DC should focus on understanding the difficulties that women doctors face in pursuing their careers, and facilitate their retention in the work force.

This incident proved to be a flash point for women doctors in Pakistan and led to an intense debate regarding women doctors' contributions to the health sector in Pakistan on one hand, and the state of social equity and gender empowerment on the other. Many, men and women doctors included, lauded the quota based restrictions suggesting that some measure is needed to restore "equal representation" in the medical workforce. In their view, if men and women doctors were numerically equal in the workforce, it would suggest that the distribution of resources and opportunities for men and women in the medical workplaces and outside is just and equitable. Others opposed this move as it deprived women students of their opportunity to access education and did not address the deeper societal processes creating difficulties for women doctors. In this perspective, however, women's participation in the labor force is equivalent to gender empowerment, a view that does not account for inequitable gendered distribution of work between men and women. Even as Pakistani women participate in paid work in increasing numbers, the distribution of care and domestic work remains more or less unchanged and unchallenged.

This issue of women doctors in Pakistan represents an intriguing social problem emanating from a complex interaction of individual, social and material factors which raises several important theoretical and practical questions. Surveying the previous



research on the broader issue of women's participation in the labor force and particularly underrepresentation of women in science, one is left with the impression that it has focused primarily on the structural barriers to women's advancement, without taking in consideration how equity and justice are defined in each cultural context. It does not account for the underlying subtle (and changing) gendered power relations that permeate everyday life and which can constrain (or enable) the choices of women. It also does not address how women are not simply constructed as subjects within intersecting power relations, but actively construct meaning in relation to them. It raises interesting questions about the cultural shaping of subjectivities, identities and agency of women within the web of power relations in a society such as Pakistan.

Before this study, little was known about the experiences of women doctors in Pakistan. Our perceptions came entirely from the media who alternately portrayed women doctors as selfish individuals who became doctors only to make themselves attractive in marriage market, or as powerless victims who were caught in the familial and cultural restrictions. Conspicuously absent from these narratives were the women doctors themselves. Who were they? Why did they decide to become doctors? What difficulties had they encountered while working as doctors? What made them leave the workforce? And most importantly, what did they think about their lives, their choices and their work? What does it mean to be a women doctor in Pakistan?

These are some of the questions that I examine through this dissertation, and as I briefly preview below, the answers that I found are not always straightforward. Women doctors are a diverse group of women, some of them come from upper class, urban,

highly educated families; others are the first ones in their family to have a college education; all of them are high achieving individuals, product of an educational system which is marked by cut-throat competition over few resources and opportunities. They are also members of a society which is deeply patriarchal. The social system of Pakistan is based on the entrenched gendered hierarchies between men and women, where the place/space of women is tied firmly to the private sphere of domesticity. Women's mobility, their bodies and sexuality are associated with the honor of their families and hence tightly controlled. Women's education is considered useful only so far as it makes them attractive life partners for educated men, or competent mothers who are able to introduce modern scientific efficiency to the running of the household and bringing up their children.

In this background, the profession of medicine is a unique niche. The customs of Purdah (a system of modesty and honor that is based on gender avoidance and seclusion) demand that men and women remain segregated even in public spaces. Because of these customs, women doctors are needed to provide services to women patients, to do the "women's work" so to speak, and hence there is a need to train women as doctors, and a relative acceptance of women's work as doctors. However, medical training is unlike other educational pathways; it is geared towards a profession, with the expectation that all women doctors will participate in the public sphere and paid employment. This however runs counter to the patriarchal order of Pakistani society where women's work outside the home is always secondary to their domestic duties, and less important than the paid work done by men. Women doctors are hence caught between the opposing demands of the

roles their society and family expect of them, and the requirements of the career in which they have invested time and effort.

In this study I wanted to go beyond a simplistic explanation of “family” so the discussion is filled with the stories and perspectives of women. These are meant to show the complex interplay of multiple factors as women doctors tried to negotiate their family and career. As doctors, they were trained for a profession that has a culture of overwork. The ideal image of a doctor is someone who can give all *his* time to work while someone else takes care of all family demands (I am using “his” since this image assumes a masculine worker). The structure of medical work and medical training demands complete devotion, to the exclusion of any other responsibility. It assumes that to rise to professional excellence, rank and status, a doctor will be able to accumulate experience, and pass through status passage points while taking little or no break. Most women doctors can neither relate with, nor fit in this image. Their careers are marked with breaks, stops and starts and changes, for which they pay the price. They are under-represented in the higher ranks of the medical profession and are generally paid less than their men colleagues. As bearers of the honor of their family, they are socialized to avoid non-kin men, to be modest and demure. But as doctors, they had to contend with the demands of a modern work structure and work place. They have to build relationships and contacts in their workplace, interact with their co-workers and learn a new way of being a woman.

Women doctors also pay the price for their career in their homes. The ideology of motherhood in Pakistan is of a selfless individual who puts her family before anything.

Women's decision to participate in their career is then seen as selfish or overly ambitious, putting their own happiness before their children's. Pakistan's multigenerational system can be a blessing for them or a curse. In some cases families can provide women doctors with support and childcare, which enables them to lean into their career, to join non-traditional specialties where few women doctors venture and to be successful. In other cases, living in a multigenerational home increases the care responsibilities manifold. In almost all situations however, the division of labor between men and women remains unchanged. The domestic work, and caring is seen as inherently feminine, and participating in it is a cultural taboo for men that is rarely broken. If younger generations of women (who previously handled the bulk of domestic responsibility and care work) leave the home to work, the care work is redistributed among older generations of women and low paid domestic workers (also women), and the gendered notions of care and paid work remain unchanged.

Women doctors are not passive victims of these structures, however. As highly educated, professional women, they are aware of the cultural constructions regarding their work and gender roles. They also have access to alternative discourses of freedom, individual rights and choice. By their presence, they challenge and change the spaces which were previously considered masculine. They define on their own what empowerment means for them. Instead of limiting work to the boundary of paid employment, they use their skill and training in a practice of care that challenges the boundaries of work in the medical profession. They determine which aspect of life holds more value for them, offers more fulfillment and joy. In doing that, while they use the

language of choice and decision, their stories indicate a choice gap created by the double bind that results from the conditions of work in their profession and in their homes.

The stories of these women are far from over. When I met them, many of them were still in the process of redefining themselves. Some, who have just embarked on their careers, are in the process of negotiating a compromise between the demands of their work and their families. Others, who had left paid work to care for their families, are finding their place through the value of care, or trying to return to the career which they left with a sense of agency that is tempered with trepidation. The experiences of these women hold important lessons for the future. Unlike popular portrayals in the media, these women are not “traditional,” ready to forgo their jobs, not motivated enough or invested enough in their work, or merely attempting to make themselves attractive as future spouses. But they are fighting against a workplace and family structure that is stuck in the traditional work structure, and which has resisted their attempts to change it. As the stories of these women show, both men and women, future generations and older ones, pay the price of this toxic structure of work which has become the norm in the Pakistan’s medical institutions. The exit of women doctors from work is a silent plea against the battle between career and family in which nobody wins. And as the state of the health economy of Pakistan shows, the price paid is not just personal and professional but also social and economic.

The rest of this dissertation is organized as follows. The first section sets the background for the research. The first chapter in this introductory section briefly traces the history of women in the medical profession in Pakistan since the colonial era. In the

subsequent chapter, titled “Study Design”, I discuss my research methods, followed by an explanation of my approach to analysis and various checks of trustworthiness that I have employed. I also discuss various challenges of translation, both as inter-linguistic and inter-cultural communication. I also explain how I situate myself within the research context, how I started my project, how was I positioned within the social community of doctors, and various hurdles in doing critical research in a patriarchal society like Pakistan.

The next section is titled “Becoming a doctor” and contains Chapters 3 and 4. In this section I discuss the decision to become a doctor from the point of view of multiple social actors. I particularly highlight the role of families in educational decision making, as well as the structure of education in Pakistan, which forces students to make potentially career altering decisions at a very young age with little information or counselling. Marriage particularly acts as a watershed point in the life of Pakistani women, as it marks a time of immense transition. Families by birth and by marriage often have very different stakes and interests in women’s education. Chapter 3 thus focuses on the attitudes of family-by-birth, while Chapter 4 discusses how medical education has become important in the marriage market. In these chapters, my focus is on the narratives of women doctors and their families to understand the attitudes prevalent in Pakistani society about medical education for women, and to discuss various strategies that women doctors employ to negotiate, resist and subvert the discursive structures in which they are embedded.

The second part of the dissertation entitled, “Being a doctor” contains Chapter 5, 6, 7 and 8. In Chapter 5, I discuss multiple restrictions on the everyday mobility of women in Pakistani society. I further trace multiple connections between mobility and educational and career choices. Although women’s differential mobility has been linked to gender based occupation segregation, this topic is particularly important in the case of Pakistani women doctors. Not only do mobility related restrictions affect their educational and career choices (for example, women prefer those specialties which have fewer night time duties), everyday difficulties in commuting to work can lead to their withdrawal from the workforce. Finally, I use the example of driving by drawing on journey-to-work stories of women doctors to understand how women doctors negotiate and challenge the gendered construction of public spaces in Pakistan. In Chapter 6, I focus on the micro-processes of interpersonal relationships within workplaces. The norms of modesty and purdah that I discuss in this chapter not only affect how men and women doctors relate to each other and enact various identities in workplaces, but also profoundly inform almost every aspect of social and material life in Pakistan. In Chapter 6, I discuss the differential specialty choices by Pakistani women doctors. Particularly important in this regard is the expectation of long term and short term work-life conflict. As a result, women doctors tend to prefer specialties that have a more predictable work schedule and shorter training periods. I also discuss the possible implications of these differential choices for Pakistan’s health care system. In the last chapter in this section, titled “Equity in the Workplace: The Role of Public Policy”, I discuss different policy structures that affect women doctors’ work within medical workplaces. I also explore the administrative burden associated with various family care policies, especially

highlighting the role of family and social norms in mediating access to these important resources.

The final section, titled “Working as a doctor”, contains the last two chapters of the dissertation. In Chapter 8, I discuss the informal practice of medicine by women doctors of Pakistan. Although this type of practice is important for both women doctors and their communities, since it is done outside formal institutional settings and it is unpaid it remains invisible as legitimate medical work. In Chapter 9, my focus is on two important areas of women doctors’ work: their domestic work in their household and their professional work as doctors. By drawing connections between these two works, I try to understand how using economic value as the only ideal leads to a devaluation of care both within the private sphere of home and within public health care. Finally, in the “Conclusion”, I consider some of the implications of this research and discuss some recommendations for future studies.



## NOTE ON GENDER/SEX

Since gender is a major ongoing theme in this dissertation, I would like to, very briefly, discuss how I have operationalized gender, and relatedly, how I have denoted gender categories in the discussion that follows.

I have operationalized socially constructed gender as distinct from biological sex. I define gender as a normative category of classification constructed within the prevailing power structures. Following Butler, I see gender as a performance that “is instituted through a stylized repetition of habitual acts” (Butler 1999, 179). These habitual, routine, day to day acts are seen as masculine or feminine in socially defined and culturally specific contexts. Gender, then, is not a state of being; rather a series of acts and a constant state of doing (West and Zimmerman 1987). I also want to stress here (following Butler) that I do not assume an essential commonality (biological or otherwise) to the category of “woman”. Hence, my aim in this discussion is not to create a political category of women doctors that is ontologically united by some essential facet of their biology or experience, but to understand, first, how human beings that various social and cultural institutions in Pakistan classify and define as women and doctors are constructed as subjects within the relations of power in which they are embedded; and second, why these particular relations of power have come to be and how they are negotiated or subverted by women as they define what it means to be a woman for themselves.

Relatedly, I also want to discuss the linguistic terms I have used to denote the gender of the research participants. This is important because neither Urdu nor Punjabi (the two most commonly spoken languages in Punjab, Pakistan) distinguish between gender and sex, and there are no separate words to distinguish between the two. This is

indicative of a fundamentally different ontology of sex/gender than what has become customary in research today. The only word to denote masculinity or femininity is *gins* which translates to “kind”, and it is used for both humans and non-humans (animals, inanimate objects, abstract ideas). The word used for woman (that is, an individual who is identified as female at birth and performs acts that are more or less understood as feminine) is *aurat*, (and likewise *mard* for man). However, this term is not without its complexity. Borrowed from Arabic, *aurat* means “a thing to be hidden” and originally referred to the genitalia of either sex (Arabic uses *al-nissa* for women). Being an *aurat* in Urdu can be a sign of marital status, since a *lurki* (girl) becomes an *aurat* after she is married (Case in point, in matchmaking terminology even adult men and women are referred to as girls (*lurki*) and boys (*lurka*)). It can also be a sign of maturity and adulthood, for if one wants to stress the adulthood of a person, they would call them an *aurat* or *mard*. Thus, depending on the social context, one can be a *lurki* (for example in a position of immaturity, as a junior doctor), an *aurat* (on one’s identity documents), a *khatoon* (in positions of respect), a *mai* (a word used for women of lower socioeconomic status) or a *bibi* (a word used for uneducated women or as a slur, originally a neutral surname for all women). And finally, to be called an *aurat* can also be a slur for both men and women. Performance of gender/sex hence is seldom done and understood in isolation with the performance of status and class. More importantly, the women doctors that I talked to during the course of my fieldwork, preferred to use “female” for themselves in English, using neither *aurat* nor woman.

I have used the terms woman and man to denote gender throughout the dissertation. I have preferred it over male or female so as not to confuse the socially

constructed aspect of the gender performance with the biological aspects of it (though it is debatable how useful it is to distinguish between sex and gender). It makes for some awkward phrasing like man doctor, man student, man physician etc. But I am choosing to stay with this jarring phrasing, because of two reasons. First, to use alternative terms like simply doctor or male doctors would have sounded smoother but it would be inconsistent when I am using women doctors throughout the dissertation. Second, the difficulty of distinguishing the masculine gender (man doctor) from the universal (doctor) exemplifies the symbolic violence that is built in the linguistic structure of human society. It is perhaps advisable in this case to use awkward language to question the gender stereotypes of certain roles.

## CHAPTER 1

### WOMEN, DOCTORS, PAKISTANIS: A BRIEF HISTORY

It is difficult to ascertain exactly how many women are doctors in Pakistan. Medical colleges and institutions do not keep gender segregated data of their graduates, so it is not possible to exactly track how enrollment of women in medical colleges has changed over the years, though anecdotal records cited by various officials to multiple newspapers and quoted by PM&DC in court proceedings suggest that the number of women students in many medical colleges may be as high as 80%. Not using gender as a category in data collection contributes further to the invisibility of women doctors in Pakistan.

In terms of the percentage of women who are registered general practitioners (GP), the best data is recorded by the Pakistan Medical and Dental Council. To become a GP, one has to complete at least five years of medical education, followed by one year of internship (called a house job) and then file a formal application with the PM&DC. This number is not an exact estimation: it still excludes those who did not finish medical education, did not complete a house job or opted out of registration altogether (and this can be for a number of reasons, like not continuing practice or emigrating out of Pakistan). It also includes those who are registered to practice but don't and those whose registration expired some time ago and was not renewed. It is also does not account for multiple, undocumented aspects of medical practice as I discuss later in Chapter 8. Hence, while the number of registered medical practitioners grossly underestimates the actual medical work going on, it still provides some estimate of women doctors in Pakistan's medical workforce. According to PM&DC, as of 2016, out of 196,647

registered GPs, 86,669 (44%) are women and out of 37,573 registered specialists, 11,410 (30%) are women. Furthermore, the percentage of women registering as GPs every year has been fairly constant in past decade or so (see Figure 20, Appendix A). Similarly, there is no country-wide, aggregate employment data available for doctors to know how many women doctors are currently employed. However, data of doctors employed in teaching and tertiary care hospitals in Punjab from the Specialized Health Care department provides some evidence: Men consistently outnumber women at all levels of career and in administrative positions, and this under-representation is progressive, i.e. it increases as women progress through their career.

Therefore, despite the high enrollment of women in medical colleges, it is clear that a good number of them do not enter the medical profession as formal practitioners. Although the under-representation of Pakistani women in the medical profession has become an active focus of research only recently, it has its historical basis in exclusionary practices which created various barriers for women joining the medical profession, or kept them restricted to low paying, low prestige jobs (like nursing and midwifery). The roots of these practices can be traced back to the introduction of modern medicine in South Asia. The history of women doctors in Pakistan highlights the colonial and gendered discourses implicit in the structuring of medical education and careers in Pakistan that persist to date.

#### A Brief Note on Terminology

The Indian sub-continent remained under the rule of the British Crown from 1958 to 1947, a period referred to as the British Raj or simply the Raj. In 1947, the British Indian Empire was divided in two sovereign states, India and Pakistan, an event

commonly called “partition.” This was followed by the largest mass migration in human history (UNHCR 2012). An estimated 14 million people were displaced in population redistribution between two new countries. In 1971, Bangladesh (hitherto East Pakistan) also seceded from Pakistan, becoming a sovereign nation.

In subsequent discussion and throughout the dissertation, British India refers to the part of Indian subcontinent that was under the British Raj before 1947 (and includes territories that are now Pakistan, India and Bangladesh). India refers to the Republic of India after 1947, and Pakistan refers to the territory that was West Pakistan before 1971 and the Islamic Republic of Pakistan after 1971.

### **Before 1947: Introducing Modern Medicine in British India**

#### **A White Man’s Burden**

In the Indian sub-continent Western medicine was introduced as the Indian Medical Service in 1764 to serve the needs of the British. Initially “natives” were employed only as paramedical staff (compounders, dressers, etc.) in the Subordinate Medical Services, as the British Government loathed to allow native doctors to temper the health of its officers. The policy of employing British trained doctors did not work well however, and the first medical college in British India, established in 1822 exclusively served Europeans. It wasn’t until the early nineteenth century that a decision was made to train “natives” as doctors because of s growing demand for doctors trained in Western medicine. Medical College Hospital, established in 1835, became the first local institution to award medical degrees, and at least initially women (native or otherwise) were not allowed to enroll (Chatterjee, Ray and Chakraborty 2013).

The introduction of women in the medical profession in British India interestingly came through the bio-political concern of colonial state with the women's bodies as a way of facilitating social control, and keeping the masters and subjects healthy.<sup>5</sup> Initially, women *dais* (women healers and birth attendants that primarily took care of women and children) were employed to perform examinations on local prostitutes to check the spread of venereal diseases in the British army (Arnold 2000, 90). Later on, when Christian medical missionaries from both sides of Atlantic took on the task of performing a “double cure” (Arnold 2000, 88) – healing the spirit as they healed bodies – the customs of *pardah*, a system of seclusion and segregation of women, created a demand for women trained in the medical professions. The secluded *zenana* (women's living quarters in the house) was seen as an impenetrable stronghold of “native” ignorance, and women medical missionaries were the only ones who could access it (Nair 1990). The first woman medical missionary, Dr. Clara Swain, a graduate of women's the medical college of Pennsylvania, arrived in the subcontinent in 1869 (Mukherjee 2012). The first British woman to practice medicine in subcontinent, Dr. Fanny Butler, was the first qualified medical missionary from the Church of England Zenana Missionary Society who arrived shortly afterwards in 1880. She was in the first class of the London School of Medicine for Women (LSWM). However, at that time, while British women were allowed to attend

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<sup>5</sup> This trend in the Indian subcontinent occurred parallel to the global rise of biomedicine, where allopathy gradually replaced traditional medical systems. This process resulted in increasing medicalization of maternal and child care, where knowledge and practices of traditional healers (many of whom women) were discredited. Ehrenreich and English (2010; 2005) particularly point out how the medicalization of women's bodies has resulted in women losing control of their health decision making.

full course of medicine, no institution in the United Kingdom allowed them to undertake the examination required for the license to practice, and women were unable to practice in the United Kingdom. It was in 1877 that the College of Physicians in Ireland allowed women to appear in licentiate examinations and practice medicine, and Fanny became a qualified medical practitioner (Balfour and Young 1929; Arnold 2000, 81; Forbes 1996).

These missionary women felt the need to train local dais (birth attendants and healers) and midwives to assist them and to help reduce the infant and maternal mortality rate. Multiple funds and programs were subsequently set up to recruit local midwives, train them in Western birth methods and hygiene, and provide them with basic “kits” to carry out safe and hygienic deliveries.<sup>6</sup> However, because this training was premised on dais renouncing their old practices and accepting the superiority of Western medicine, it effectively alienated local women healers and they refused to adopt or train in Western

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<sup>6</sup> While it is tangential to the discussion it is important to mention here that this seemingly benign, even beneficial concern for the health of women served imperial colonial purposes in more than one ways. For one, it created a rhetoric of “dangerous dais”, where local practices of birthing were labelled as unhygienic and dangerous (colonizing local systems of knowledge), and dais were held responsible for high maternal and infant mortality rates. Secondly, those dais and midwives who were trained under these programs were given incomplete information and resources to increase their dependence on colonial doctors. They were given incomplete kits (that included soap and other material for hygiene but did not include chloroform or forceps). They were taught only to recognize signs of danger and refer the patient, instead of being able to treat themselves. Moreover, through these practices, a hierarchy between Western (colonial) medicine and local (colonized) medicine was established, with doctors withholding information and tools to protect what they considered their legitimate turf. Interestingly, this particular confrontation continues to date. Dais are still considered dangerous and their unclean practices are still deemed responsible for high infant and maternal mortality rates in Pakistan. The safe birth kits issued to traditional birth attendants still contains only soap, a clean plastic sheet, a razor and cord ties (and no forceps, speculum or any anesthetic).



medicine (Soman 2011; 2013). A few women dais (local healers) who were trained by these programs were often employed by the urban elite in missionary hospitals as paramedical staff, where they served on side lines while British trained, male doctors took the credit (and money) for successful deliveries (Forbes 1996). Although the first entrants to Western medical profession were dais and midwives trained by missionary medical workers, by 1883 medical colleges and schools established in Bombay (Mumbai at present), Madras and Calcutta started admitting women students (Arnold 2000).

### Saving the Secluded Women

The intersection of the customs of purdah<sup>7</sup> and practice of medicine had interesting consequences for both the colonized and the colonizers. Providing services to the native women was seen as an imperative of “white man’s burden.” The norms of purdah became the *raison d’etre* for the growing demand of trained women medical practitioners in the subcontinent who could access the hitherto un-colonized zenana (feminine quarters). The moral responsibility and civilizing mission of the British Raj mandated providing medical aid to Indian women, who were otherwise left to suffer under the patriarchy and ignorance of native Indian men, was one of the major reasons for opening up British medical colleges for women. British women doctors who found it difficult to practice back home, arrived in the Indian subcontinent to pursue a lucrative medical career. Thus, the professional women who would have threatened the gendered order at home were comfortably removed to British India where they served the colonial

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<sup>7</sup> A religious and cultural system of gender seclusion and segregation that I discuss in Chapter 6

project of governing the bodies of women through increasing medicalization and simultaneously reinforced the gendered hierarchies created by purdah. At the same time, by respecting the local customs of gender segregation, British Raj kept up the appearances of being respectful and humane (Forbes 1994).

Similarly, the powerful rhetoric that women medical professionals are required to serve the *purdah nasheen* (observant of purdah, literally those who sit behind a curtain) made it relatively easier for women to get admission in medical colleges in British India. The British as “enlightened outsiders” considered it their moral obligation to upgrade the living conditions of the “natives” and they were convinced that to save the women of subcontinent “either from a life of suffering or from premature death,” a large number of qualified women medical professionals were needed (Director of Public Instruction in Bengal, Sir A.W. Crofts, as quoted in Mukherjee 2012, 13). This concern for the development and emancipation of women was not directed towards their particular social context nor did it address the nature of social relations in which these women were embedded.

As Chatterjee (1989) points out, these policies resulted from the direct “political encounter of a colonial state with the ‘tradition’ of a conquered people.” Purdah was-and still is-a complex system that pertains to social interactions. More importantly, not all ethnic and religious groups in India practice purdah, and customs vary depending on the region, caste and religion (Hindu and Muslim purdah differ significantly in practice, and the religious ethics on which they are based). The British assumed the universality and homogeneous experiences of purdah and then, for the first time in India, proceeded to institutionalize gender segregation in education, employment and public spaces in the

name of reforming and alleviating the inequalities created by “local traditions” (Arnold 2000). By building women-only hospitals, parks, and educational institutions they created a new zenana (women’s quarters), and created a separate “women’s place” in the public sphere. This creation of women’s place has important implications for women doctors even today, as I discuss in Chapter 5 and 6.

### Together but Unequal: Native Women Doctors

Colonial discourses in medical education for women are best exemplified by the occupational segregation created by the intersections of gender, race, religion, caste and class. The majority of initial women medical graduates in British India before partition belonged to enlightened, educated, well off families, and apart from a few exceptions, most of them were Europeans or Eurasians (a term for descendants of Europeans and native Indians). Medical training programs for women funded and administered by missionaries were similarly targeted towards Christians and converts (Forbes 1994). Moreover, medical education was not uniform for everyone and the British ensured that medical education was tiered according to gender, class and ethnicity. More rigorous and prestigious medical programs (like MD, Doctor of medicine, which took four years of education) were offered only to European and Eurasian men, while local men were generally admitted to less prestigious medical schools or trained as hospital assistants (vernacular licentiate of Medicine and Surgery, VLMS) rather than doctors and surgeons. Similarly, European, Christian and Parsi<sup>8</sup> women were admitted to more prestigious,

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<sup>8</sup> A religious minority in India and Pakistan now, the Parsi are Zoroastrians and migrated from Iran between 8th to 10<sup>th</sup> centuries CE.

three years long MB, bachelor of Medicine) while Hindu women (with very few low caste and Muslim women) were admitted to a less prestigious certificate program. Both these programs for women were considered less prestigious and less rigorous than those offered to men (Forbes 1996).

More importantly, this stratification was a product of subtle differences in admission and education policies, rather than direct denial of admission. More prestigious programs (Bachelor or Doctor of medicine) were taught in English by mostly British teachers, so they required proficiency in the English language. These programs also had more stringent admission requirements (an admission test and a certain level of formal education). Consequently, few Hindu or Muslim women qualified for them as they were rarely formally educated, and did not generally speak English (Mukherjee 2012). In comparison, VLMS Licentiate programs had minimal requirements of formal education, the curriculum was in local languages and these were usually taught by native Indian teachers and thus mainly had Indian (Hindu/Muslim) students.

The presence of women in medical colleges was a challenge in itself. Medical education involved discussion of specific parts of body and discussion of their function. The presence of women during these discussions threatened the patriarchal order, where the masculine body was opened to the feminine gaze (Sen and Das 2011). Hence the presence of women in the same class rooms as men was initially considered immodest. Usually a curtain or screen was hung in the middle of the class room to separate men and women students. In other cases, men and women students had separate dissecting rooms and separate classes.

This policy of admitting local women to medical colleges was however, not without its opponents. Indian Medical Gazette and other journals attacked the government again and again in their editorials (Forbes 1994). It was opined that the needs of women could be fulfilled sufficiently by trained women nurses and there was no need to allow local women to be doctors. Some went on to suggest that assuming that women of the subcontinent were fit to be doctors, or that native women doctors were needed at all, was nothing more than exposing local women to moral corruption perpetuated by the British Raj by allowing them to mix freely with men during their education and career (Forbes 1996). Women medical students were exposed to threats of harassment, bodily harm, abduction and even rape (Forbes 1996, 165). The women students who studied in co-educational classes, worked with men and travelled alone were perceived as morally corrupt and promiscuous (Forbes 1996). Dr. Virginia Mitter, one of the first women graduates from an Indian medical college, gave up practice after marriage as her husband was opposed to her employment. Others like Jamini Sen had long successful careers but gave up matrimony altogether (Forbes 1996).

Medical education for women was funded by the National Association for Supplying Female Medical Aid to Women of India through charitable donations by wealthy British and Indians. More commonly known as the Countess of Dufferin Fund, it was established in 1885 to provide scholarships for women doctors in colonial India, train midwives, build woman-only hospitals and annex zenana wards in already existing hospitals (Maneesha 1994; Mukherjee 2012). Aimed at fulfilling the needs of women in zenana, the fund took the cultural norms of purdah as an unproblematic, monolithic and homogeneous construct (and disregarded its variances in multiple intersections of class,

caste and religion). The administrators of the fund (vicereine and wives of British officials, the *memsahibs*) also assumed that all women of India preferred to visit women physicians in women-only hospitals, and since enough Indian women could not be trained in medicine to fulfill the culturally constrained medical needs of *zenana*, the hiring of British women doctors was warranted. Hence, instead of providing jobs and education to local women medical professionals (as it was purported to do), the administration of funds recreated and reinforced the race and gender biases implicit in medical education (Mukherjee 2012). In hospitals and wards created by the Dufferin fund, British women doctors held most of the administrative posts, worked with better pay in urban centers, and were politically active through the Association of Medical Women in India (AMWI). Unlike native medical women, who were hired only as assistants in hospitals, British women held degrees that could be registered as doctors in Britain, and this quickly served to establish a professional hierarchy.

British women doctors were quick to distinguish themselves from “lady-doctors”, decrying the lack of training among local women medical professionals whose incompetence they thought would only serve to discredit Western medicine. They also began to assert their professional authority over the realm of the *zenana* (women’s quarter) by stressing that, as professional qualified women “doctors”, they could best serve the needs of *zenana* (woman) patients. This shows how the patriarchal project of medicalizing women’s bodies overlapped with colonial discourses to structure women’s thoughts. British women doctors emphasized their professional competence over the local women doctors and argued that outside interference in women-only spaces (by men doctors) angered the local women because it violated norms of *purdah*. Thus they

challenged the other two groups vying for the right to speak for the native woman patient (who was conveniently assumed to be voiceless): First, the memsahibs and medical missionaries who administered the Dufferin Fund, and secondly, the male surgeons and doctors of Indian Medical Service (IMS) who oversaw all hospitals (including women only hospitals) and were called in to assist in difficult surgeries even for women patients. Staking their claim over Indian women patients, British women doctors demanded a separate women-only medical service, modelled after IMS, with a woman surgeon in charge of all women-only medical facilities, specific hiring, promotion and retention policies and better pay. The Women Medical Service (WMS) was set up as a result in 1914, and assumed responsibility of administration of all Dufferin Hospitals (Mukherjee 2012). This move effectively established a separate women-only medical profession which worked for women patients in women-only spaces.

In this way, British women doctors simultaneously distanced themselves from local women medical professionals and asserted their equality in status to their British men counterparts. The intersecting discourses of customs of purdah and the medical profession in British India consequently became important precursors for professionalizing women doctors in Britain and providing them with employment opportunities. But, medical education and practice for local women doctors suffered as they were often paid less and excluded from important positions, while lucrative positions and high paying jobs were taken by British women doctors (Forbes 1996, 166).

#### In a Double Bind: Muslim Women in Modern Education

As I mention above, religion was an important determinant of a woman's access to education: While majority of the elite, upper class, high caste Hindus (called *Brahmos*

or *Brahmo Samaj*) aligned themselves with Western education and medicine (and upper class, urban, high caste Hindu women formed a majority of women medical professionals in British India), few Muslim women had access to medical education (Chakraborty 2011). In Campbell Medical School, Calcutta, for example, the first Muslim woman was admitted in the VLMS program in 1891, and between 1936 and 1940, there were only 19 Muslim women trained as hospital assistants (Forbes 1996).

It is pertinent here to briefly mention the dilemma that Muslim women faced when it came to education. Faced with the threat of losing to a Hindu majority under British rule, Muslims nationalists sought to carve out an identity that was simultaneously non-Western and non-Hindu (Minault 1998). As Chatterjee (1989) points out, women became the sole focus of nationalist ideology in British India. Entrusted with the task of carrying on eastern traditions of spirituality and purity, women's place was firmly tied to the inside of home, a space that was reimagined as the last refuge of Eastern values, while the masculine, public sphere was gradually Westernized. The question of "reforming women" through the discourses of purdah, education and employment became a corner stone in this debate (Chakraborty 2011). Muslim reformists (like Sir Syed Ahmad Khan) who advocated Western education for Muslim men did not want to extend this access to Muslim women to ensure "domestic happiness" (Minault and Lelyveld 1974). Others, like Hali, although actively advocated for modern education for women (or *Taleem-e-Niswan*, as it came to be known), wrote edifying texts and novels targeted towards women audience and opened schools for them, still wanted education to make women better companions for educated Muslim men and to be better in their feminine roles and duties of housekeeping and child rearing (Minault 1998). The ideal model of education,



particularly for Muslim women, was one that did not remove them from the realm of their home, but at the same time made them ideal match for the generation of newly educated Muslim men. Unlike their Hindu counterparts, few Muslim women attended formal schools, relying instead on religious and edifying texts (some of them specially designed for women like *Baheshti Zewar* (Paradise's Jewelry) and some basics in language and mathematics taught at home by women teachers (Minault 1998; 1994). Educational reformists trying to make women's education more palatable stressed that primary importance of education was not to gain employment and to earn money (like the Western women) but to develop human faculties and to be better mothers. Needless to say, there were few Muslim women who were formally educated and fewer still who sought professional education and employment.<sup>9</sup> Muslims also suffered more from prejudice at the hands of the British colonizers as compared to the Hindus. At the time of the partition of British India, Muslim majority provinces (which later formed Pakistan) had only two medical colleges, while Hindu majority provinces had 27 (Sen and Das 2011). Thus, Muslim women had even fewer opportunities to study medicine. As a result, when Pakistan and India became sovereign states in 1947 after partition of British India,

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<sup>9</sup> I must mention here that this experience of identity crisis and barriers to education was not same for all Muslim women. It was the Muslim women of middle to higher class, high caste families, so-called "*shurafa*" who could afford any kind of education at all. It was this class where customs of *Purdah* were most rigorously practiced and women's employment was frowned upon. Women who belonged to lower (or working) classes probably could not afford the exclusive educational institutions but their participation in various forms of employment and their freedom to access public spaces and move between masculine and feminine quarters of the home was more culturally acceptable; perhaps since it was assumed they had no need of the respect that was associated with *purdah*.

the newly created state of Pakistan had very few trained women health practitioners and even fewer women doctors.

### **1947 to Present: Women Doctors in Pakistan**

In 1947, at the time of independence of Pakistan, there were only two medical colleges in the newly created state (King Edward Medical College and Dow Medical College), and only 48 doctors and 188 nurses.<sup>10</sup> Needless to say, this health care force was insufficient to provide services for the whole population. Interestingly, the argument of providing medical facilities to women in seclusion while respecting the sacrosanct space of *purdah* became an important factor in the introduction of medical education to Pakistani women as well. To counteract the acute shortage of women doctors, the first medical college established in the new state was a women-only institution: Fatima Jinnah Medical College (FJMC) named after the sister of Muhammad Ali Jinnah, founder of Pakistan, who was a dental surgeon herself. FJMC admitted its first group of 36 women in 1948.<sup>11</sup> Still, this paltry number was not enough to cover the needs of women patients. Therefore, approximately 20% of all seats in medical colleges were reserved for women.

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<sup>10</sup> Data obtained from Pakistan Bureau of Statistics, available at [www.pbs.gov.pk/sites/default/files/50\\_years\\_statistics/vol1/13.pdf](http://www.pbs.gov.pk/sites/default/files/50_years_statistics/vol1/13.pdf). There is no data to indicate how many women were among these doctors. It is also worth pointing out that LMS certified women medical professionals might have been slightly more numerous, but there is no data to indicate how many there were.

<sup>11</sup> At the same time, admission of women to other medical colleges (which were co-educational till now) was stopped. This policy was, however, short-lived and admissions resumed after a couple of years. A reference to these changes is found in the history of King Edward Medical College (available at <http://kemu.edu.pk/history/>) and the decision of Supreme Court of Pakistan, *Shrin Munir and others v. Government of Punjab through Secretary Health, Lahore and another* (PLD 1990 SC 295).

Initially, this admission policy was imposed by the state to ensure that a certain number of women students were admitted to medical colleges. However, over time, medical education became a popular professional choice especially for Pakistani women of the upper and middle class. Since British trained men doctors often had lucrative practices, and were well connected and respected in their communities, the profession of medicine became a symbol of status and social capital. Moreover, because women doctors often worked in women-only hospitals or in their own private practices, it was seen as an “honorable” profession since it complied with the cultural restrictions of *pardah* (I discuss these aspects in detail in subsequent chapters). As the number of women applicants increased, the 20 percent of seats reserved for them by the government became insufficient, and women students were often denied admission. As a result, in 1990, this quota was challenged in Supreme Court of Pakistan.

Women students challenging the gender based quota in Supreme Court argued that, because of this policy, women students with higher grades (and therefore of higher merit for admission) were denied admission, whereas men students of lower merit were admitted. Since the constitution of Pakistan granted women equal rights, stipulating that all are equal before law and no discrimination can be made on the basis of sex alone, denying admission to women who qualified for medical colleges constitutes discrimination. The Supreme Court in their decision upheld their argument, further noting that, while it is lawful under the Constitution of Pakistan to reserve an educational institution for one sex,<sup>12</sup> once co-education was allowed, admissions must be on the basis

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<sup>12</sup> Pakistan’s legal system does not recognize the distinction of sex and gender, so “sex” is the word used in Pakistan’s constitution. See *Shrin Munir and others v. Government of*

of merit alone. This decision set a historic precedent that not only opened the doors of all medical colleges for women, but all professional colleges and universities as well.

It would seem surprising that in the presence of such clear a precedent, any gender based restriction on admission would be re-introduced. That is why it is important to understand the assumptions and ideological underpinnings of the quota-based admission policy introduced by the Pakistan Medical and Dental Council in 2014. Replacing open merit, which meant equal opportunity for anyone to apply regardless of gender, with a quota that divided seats equally between men and women students, PM&DC was interpreting justice and equity as based on numerically equal representation. Indeed, their lawyer suggested in court that the ratio for dividing the seats was based on the sex ratio of the Pakistan's population (i.e., women students should have the same representation in medical colleges as they had in general population). A senior professor and head of a large postgraduate institution was similarly in favor of quota-based admission, as he explained, "Women in Pakistan have more than equal chance at every opportunity. They have quotas reserved for them in employment and in parliament and they can compete with men on open seats as well. So if there can be gendered based quotas for women, why cannot some seats be reserved for men students?" He went on to argue that this is not a quota for women, but for men. Because women are unable to work because of their familial constraints, it is necessary for Pakistan's health economy that some seats are reserved for men. In a formal conference where I presented some of the

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*Punjab through Secretary Health, Lahore and another* (PLD 1990 SC 295) for details of this decision.

findings from this study, I was similarly asked how “equally” dividing seats between men and women constituted discrimination. Was it not the “equality” that women were demanding all along?

This perspective particularly highlights the importance of representative as well as redistributive justice to ensure social equity. Redistributive justice refers to equitable distribution of opportunities and resources, while representative justice refers to equal recognition of various identity groups in the society. Adding women in organizational structure or in educational institutions (that is, giving them representation) does not guarantee that the gendered biases that permeate society disappear, nor does it mean that gendered power relations that exist within organizational structure no longer operate (Bacchi 1990; Fraser 1997; Fox 1998; 2001). Thus, even with equal representation, the redistribution of resources remain elusive (Fraser 1994).

### **Speaking of Women in Pakistan**

Before I delve in questions of equity and justice, it is necessary to briefly understand the discursive context in which the debate of women’s rights and empowerment takes place in Pakistan. The issue of women’s rights has been central in nationalist movements in British India, where women were positioned as the guardians and protectors of an authentic national identity (Chatterjee 1989). This continued after partition when women became the substrate of contesting debates of nation building and forging a distinct identity for the newly minted states of Pakistan and India (Charania 2014). Islam had played an important role in the creation of Pakistan. Creating a homeland where the Muslims of British India would be in majority and hence would have the freedom to pursue their religion, individually and collectively, was the logic behind

the creation of Pakistan. Slogans like “*Pakistan ka mutub kia? La ila ha illallah* (What is the meaning of Pakistan? There is no God but Allah)” still remain popular affirming the Islam as integral part of Pakistani identity.

As Said points out (1978, 55), postcolonial states often in an effort to reclaim their identity, intensify their differences and distances from the colonizers. In Pakistan after partition, Islam was politicized and deployed as a counter power to “Western-ness”, seen as symbol of cultural dislocation under colonial rule, and continued infringement by contemporary neocolonial powers (Charania 2014; Zia 2009). These dichotomies of Islamic/Western and Muslim/liberal were often coded and mobilized through the language of women reform. Polemic texts like *Purdah* penned by religious scholars extolled virtues of Muslim femininity which remained protected in seclusion of Islam, and warned against the dangers of Western, liberal influences seeking to leave women exposed and vulnerable (Jamal 2005). This process culminated during the regime of Zia-ul-Haq, where control of women’s sexuality, their work and their citizenship through *Hudood Ordinance* and *Qanoon-e-Shahadat* (an Islamized version of British era *Evidence Act*) became the nexus of Islamization (Charania 2014). Indeed, the headscarf (*dupatta*) worn by women on national television became a barometer of religious leanings of the ruling government; Newscasters covered their heads during the more “Islamic” Zia’s regime and women actors were asked to wear modest dresses and less makeup. The struggle of Pakistani feminists against these policies was then seen as a struggle against Islam itself, and a rebellion against “authentic” Pakistani traditions and family structure. Women demanding equal rights were accused of collaborating with Western colonial forces by importing their ideas, through blind acceptance of western

values, and becoming unwitting pawns in the Western agenda against Islam (Gardezi 1990; Suleri 1992).

These divergent dichotomies leave very narrow space in which any debate about women's right can be articulated. Modern Pakistani women activists either employ the rhetoric of universal human rights (risking accusations of being Western), or contest the authenticity of religious discourses by suggesting alternative readings, risking the accusation of being bad Muslims (Zia 2009). This context is further complicated as Pakistani feminists are caught in the intersection of contemporary geopolitics emerging after 9/11 and the violent and brutal intervention of the United States in the area on one hand, and the evocation of women's rights and gender reforms in the name of political power by Western imperialism (Charania 2014). The deployment of "Western" as a pejorative is not merely descriptive, it always points to the colonial legacy of Pakistan, its anti-colonial struggles and its position in a neo-colonial geo-political landscape. This label effectively mobilizes the anxieties of a nation state about its boundaries and its identity. The accusation also denies agency and autonomy to Pakistani women through misunderstanding that feminism originated in the West, and the rhetoric of rights and equality as mobilized by women activists in Pakistan does not speak to the experiences of "real" Pakistani women. Further, it positions anyone working towards gender equity and empowerment as "non-Pakistani" and "un-Islamic", being out of touch with Pakistani traditions, and threatening to destabilize the protection of *chadar aur char diwari* (veil and four walls) that "authentic" Islam grants women (Charania 2014).

This is the background in which this study is set. The structure of medical work, its training and education have changed little since the colonial era. The discourses of

*pardah* that made it easier for women to enter the medical profession are still the reason why medicine is considered an honorable profession for women in Pakistan (as I discuss in detail in Chapter 3). The segregation of men and women doctors and patients still remain the same, though now the walls between them are invisible (as I discuss in Chapter 4). Various policies governing the structure of work, and promoting gender equity are still very much the ones present in the colonial legal system. In a way, Pakistan's workplaces have been stuck in an anachronist time refusing to change, while the demands of women doctors have changed. The second section of this brief background also explains why it is so difficult to articulate women's rights and empowerment in Pakistan. The labels of "Western" and "liberal" are not far away from any researcher who investigates women's experiences in Pakistan, and these labels come at a real price, as I discuss in the next chapter.



## CHAPTER 2

### STUDY DESIGN

#### **Locating the field**

This dissertation is based on a yearlong ethnographic study that I conducted in Lahore, the second largest city in Pakistan. Lahore, the capital of Punjab, Pakistan's most populous province, is a major cultural and social hub.<sup>13</sup> Being the seat of provincial government and many educational institutions, it has a very diverse population, not only comprising of people from other areas of Punjab, but from other provinces as well. Lahore was particularly appropriate because of the sheer number of medical institutions present there (19 public and private medical colleges, medical universities and over a hundred large public and private hospital). I also selected Lahore since this is where I studied medicine and later worked as a doctor. I had numerous contacts in the community of doctors, many of them long term friends and colleagues. Their help was invaluable in easing my access to hospitals and introducing me to many of my participants.

It was not possible for me to limit the field work to one particular location or institution because I wanted to focus on the diversity of perspectives, and because the work and life of women doctors spanned multiple spaces. Although focusing on one particular institution might have resulted in thicker descriptions, I would have missed the heterogeneity of experiences that I managed to capture by visiting multiple locations. For example, doctors working as solo entrepreneurs experienced workplaces in very different

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<sup>13</sup> As of 2016, Punjab has a population of 101.4 million and Lahore has a population of 18.5 million (Data obtained from Bureau of Statistics, Punjab. Available at <http://www.bos.gop.pk/publicationreports>)

ways than those working in large hospitals. I started fieldwork at two large public hospital-complexes in Lahore. For the sake of confidentiality, I will refer to them as Afridi Hospital and Lincoln Hospital. In each of these locations I divided my time between different departments, including some departments of specialties which are considered women friendly (like gynecology, radiology, pathology) and others where women are fewer in comparison (like surgery and medicine). I followed doctors in their daily routines, observed their work, their interactions with their colleagues and patients, and participated in their informal conversations (particularly during tea break). At each site, I introduced myself to everyone present and described the purpose of my study as clearly as possible. Since the issue of women doctors was a topic of debate at that time, it usually led to passionate discussions, with many doctors eager to share their opinion and their experiences. Although a major amount of data collection was done at these two sites, I also conducted field work (for shorter two to three week periods) at two private hospitals and a specialty public hospital (not attached to a teaching institution). Apart from these large hospitals, I visited the clinics and private practices of doctors who practiced alone. I also visited doctors in their homes, and participated in their formal and informal gatherings like get-togethers, parties, academic lectures and conferences. At each site, I jotted down initial observations in the form of scratch notes and then expanded on these notes by writing detailed observational and analytic field notes afterwards (following the method described by Bernard 2006, 387-413)<sup>14</sup>

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<sup>14</sup> I used a pocket book or typed them as a Memo in my android mobile phone, depending upon the situation since mobile phones, tape recorders and cameras were not always allowed in hospitals.

I also realized that a substantial amount of social interactions and debate happened in virtual spaces. Doctors, especially younger ones, are an active community on social media websites such as Facebook. All medical institutions have Facebook pages. Sometimes, individual hospital units and departments also have their own, separate pages. Similarly younger cohorts of medical colleges maintain “groups” to keep in touch, though they are often closed (i.e. the membership is subject to approval by an administrator and content is visible to members only). There is also an increasing trend of “Humans of...” type pages on Facebook, inspired by “Humans of New York” with individuals interviewing students, teachers and employees of medical institutions and posting the excerpts and pictures online. Medical students often maintain informal blogs of their institutions, sharing stories and articles. While I kept track of these multiple virtual spaces, and used the insights to inform the dissertation’s theoretical development, I have refrained from using any direct quotes or pictures from social media sharing sites, even when they were publically shared. This is because, particularly in the case of Facebook, privacy settings are often ambiguous and changed without the consent of users. This makes it difficult to say that sharing something publically is equivalent to providing consent for that information to be used in a research.

Finally, some virtual spaces remained inaccessible to me even though I knew of their existence. My participants for example often told me of their activity on WhatsApp (and other web based messaging services though WhatsApp is by far the most popular in Pakistan). This was theoretically significant because I realized that gendered interactions in workplaces also extended in these virtual spaces. These virtual communities were also sometimes gender segregated, and when they were not, similar patterns of avoidance

existed in the interactions occurring in them, which I discuss in Chapter 6. On the other hand, in some cases, these virtual spaces provided avenue for interactions that were not possible in non-virtual spaces. For example, doctors from multiple hospitals could collaborate on research activities and patient care. Similarly, doctors could share and spread information in these groups that they could not easily discuss in their workplace, for example, possible sexist attitudes of a certain advisor or planning political action against management. This insight however came from participation in virtual communities of my own cohort in medical college, and since I did not have consent from all other group members, I could not include any detail in my analysis. However, with increasing entanglement of technology in our social relations, inclusion of these virtual spaces in the ethnographic “field” is becoming increasingly important, even when virtual space is not the sole focus of research. I believe that there is a need to discuss and develop ethical guidelines and practices to include data from these sites, and to use virtual spaces in ethnographic studies in other ways. My participants for example wanted me to start a WhatsApp group for them, where they could chat with each other and I could share my findings and dissertation for them to read and comment. I cannot say that I was not tempted, it is certainly a very good way for this research to be more collaborative. However, it would have seriously jeopardized the anonymity of the participants, so I had to decline.

### **Selecting the Participants**

I selected the initial participants after participant observation, who I then interviewed in detail. I selected the interviewees using non-probabilistic, purposive sampling to maximize the exposure of theoretically salient social categories (like

different specialties, occupational experience, family living arrangements), as recommended by Patton (1990). Although nonprobability sampling does make formal generalization about the population inappropriate (Sandelowski 1995), it is an appropriate approach for in-depth ethnographic studies such as this, as Bernard (2006, 190) has suggested. Since I also wanted to interview women who do not practice medicine, I requested the participants and doctors that I met to introduce me to any of their class fellows or colleagues that does not work anymore, or has not practiced medicine after graduation. However, finding women who did not work took longer than expected. Although doctors were eager to help, their social networks changed at different points of their careers and education. All of them told stories of their women friends and colleagues who “fitted the description” but many of them have not stayed in touch with them. However, it was through referrals from the participants that I identified the women doctors that were not formally employed. I also requested the participants to introduce me to their family members if possible (which had its own difficulties as I discuss below).

Although I interacted with numerous doctors during the course of field work, sixty women doctors were interviewed in detail for the project (Detailed breakdown of age, educational background, marital status, specialty, employment status, organizational rank is given in Appendix B, Table 3-10). Although I initially intended to divide my research sample by interviewing women doctors who were practicing medicine and those who were not, as I discuss in Chapter 9, the experiences and career paths of my participants did not fit in these neat categories. Women doctors practice medicine within multiple institution settings and outside of them, they are not always paid for their work, and many of these alternative sites of medical practice do not have any parallel in the

current literature. To give an approximate idea, fifteen of my participants were not formally employed as doctors, thirty four were employed in a public or private hospitals (but four of them were unpaid), three were employed in public hospitals and worked in private practices as their evening jobs (that is, worked two jobs), and four were self-employed in home based or solo practices, but were paid (Table 4, Appendix B). This employment status is what I noted at the time of interview; it does not cover the whole career experiences of my participants as they had moved and transitioned across careers over their life course. Even over the course of the study, two unemployed doctors started jobs and one started post-graduate training. Three employed doctors left jobs, and two of them emigrated out of Pakistan.

To understand the familial context, I initially intended to interview family members of women doctors where ever possible. This proved quite difficult during field work since participants were often not comfortable introducing me to their families after they have shared sensitive information about them with me. Since this was an important aspect of my methodology, I attempted an alternative approach. Many of my participants were parents or parents-in-law and spouses to doctors, so I also covered this aspect of their lives in my interviews. Moreover, husbands, parents and parents-in-law of six doctors (30 individuals in total) also consented to interview, and were included in the study (Educational and employment profile of families of women participants is detailed in Table 11, Appendix B).

Gaining access to policy makers and hospital management was also quite difficult and time consuming. The regular method of calling and scheduling an appointment usually does not work in Pakistan, so I had to go to their offices and wait for a meeting.

Occasionally it took several trips before I could even meet someone. Though this wasted time was a source of anxiety for me, it was also informative in the sense that I could observe a lot of innocuous conversations going on in offices. Once I met the potential interviewees however, most of them were quite helpful. I interviewed three officials from the Health department, two from the Pakistan Medical and Dental Council, and four medical superintendents (all of them men). Apart from public administrators and policy makers, management hierarchies within the medical institutions were also important. Therefore, I interviewed three professors, two associate professors, two assistant professors and one senior registrar (all of them men). Since there were several professors, associate and assistant professors among the participating women doctors, I also covered the management aspect of their job in their respective interviews (the details of these women are given in Table 9, Appendix B). I must note here that the participants I mention here are those with whom I conducted detailed, formal interviews. As part of the ethnographic study, I had the occasion to talk to several people about various aspects of medical education and career (for example, I talked to matchmakers to understand the role of medical education in marriage market). Some of these conversations were brief, others were long and detailed, and I used the field notes to capture the details in these conversations.

### **The Interviews**

Although I had many informal conversations with participants (and other doctors who were not interviewed), interviews provided a site to record their individual perspectives and narratives in detail. The interviews that I conducted were person-centered, open-ended semi-structured interviews. In person centered interviews, an effort

is made to understand subjective and intersubjective experiences from the point of view of an “active, intending subject” (Levy and Hollan 2015, 313). It is based on the idea that social world is intersubjective connected and a person’s intentions and motivations can be understood only within the context of the social, material and symbolic discursive structure in which they are embedded. This makes this type of interview particularly suited to explore themes like identity, agency and resistance. Furthermore, unlike a traditional ethnographic interview, which is based on group level information, a person-centered interview explores how individuals experience the reality of their world and to understand, from an individual’s point of view, what it is like to live in that area. The interviewee acts as an informant (about the cultural and social beliefs in a particular cultural locale) as well as a respondent (about what she thinks/feels about these beliefs). This dual mode of questioning allowed me to explore the spaces of coherence, conflict or transformation between the participants and their context or life-world (Levy and Hollan 2015, 317).

At the beginning of each interview, I asked the participants if I could record their interviews, and audio-recorded them whenever consent for recording was granted. I started the interview with an open-ended question, like “let’s start with your childhood and schooling”. I let the participants direct the narrative, occasionally probing further or asking follow-up questions. I used questions like, “what do *you* think about....” and “what do people say about....” to gather information about the perceived discourses in the society as well as the how individuals related to them. Each interview lasted an average of 45 minutes, with the longest being 2 hours.



Interestingly, audio-recording affected the interview process to a great extent.<sup>15</sup> Most people were not open to the idea of getting their voices recorded, even when I explained that their data would remain anonymous. Others were wary that people in their families or workplaces would see the recorder and confuse me with a journalist doing an expose and that would create difficulties for them. So I expressly asked everyone for their consent before recording, and only recorded when consent was granted. In cases where the permission to record was not granted, I took detailed notes during the interview, and filled in the details immediately after the interview. I also made note of any particularly poignant phrase mentioned by the participants. On more than one occasion, once I had

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<sup>15</sup> The effect of audio recording on the data collection and interview process is well noted and it depends a lot on cultural context (for example, see Guba and Lincoln 1981; Al-Yateem 2012). Presence of recording equipment can make participants aware that they are participating in a study and make them change their responses (Hawthorne effect), or parse information about personal, embarrassing or potentially illegal issues (social desirability bias). The reluctance of my participants needs to be understood in the particular cultural and social context of Pakistan. Most women doctors were sharing personal information about their families and their work place, and they wanted to be absolutely sure that I would not share these details with anyone else. Another factor was the use of audio and visual recording in hospitals. During my field work, there were several instances when journalists made recordings in hospitals and used them for various exposes on Pakistan's health sector. In many instances, doctors were prosecuted and dismissed from service because of this. Understandably, many doctors were wary of being recorded and giving interviews lest they be implicated in such a scandal. An ever present consideration was the security situation in Pakistan in aftermath of war on terror. Lahore was struck by terrorist attacks in at least three occasions during my fieldwork (an explosion in Defense on February 23, 2017, a suicide bomb blast on February 13, 2017 on Mall road, and another blast in a public park on 27 March 2016). When I started my fieldwork, there were few restrictions on taking recording equipment inside the hospital premises, but gradually security was tightened and on more than one occasion I was stopped from taking pictures or recording. On one occasion, even after the hospital manager allowed me to record, he insisted that one of his assistants follow me everywhere. In such situations, both recording and not recording had its trade-offs. I generally preferred that my participants felt free to talk, rather than insisting on recording.

(on my part) ended the interview and stopped the recording, the participant told me that she wanted to share some other things now that the recorder was off! In all such cases, I made sure that I had the express consent of the participant to use that data in the analysis, and took notes to record the observations. Audio-recordings of the interviews were then transcribed through a professional service.

### **Translation**

Oxford Dictionary defines translation as “the process of translating words or texts from one language into another” and “the conversion of something from one form or medium into another.” The trope of translation lies at the heart of ethnography, as a project of rendering the meanings of one culture, as a text, intelligible to others (Wolf 1997). In ethnographic project, layers of interpretation and translation are integral, as its text always oscillates between emic and etic perspectives. This process begins during data collection, as “what we call our data are really our own constructions of other people’s constructions of what they and their compatriots are up to” (Geertz 1973, 9). We, as data collectors, render multiple texts (of utterances, gestures, noises, sights, smells and tastes) in our observations, and then we read and re-read these texts (broadly speaking) to understand and encode their culture specific meanings. In this section, I will use translation in its multiple meanings to explain various steps in data processing and analysis.

#### **Translation: Working Between Languages**

One important aspect of translation that I want to discuss is working between, and though multiple languages. All of my participants were multilingual. This is not unusual for Pakistan, where people often speak multiple languages fluently. For example, being in

Punjab, almost all participants fluently spoke and understood the most commonly spoken local language, Punjabi (the exception being the two participants born outside Punjab, who spoke local languages of their provinces, Sindhi and Balochi), and Urdu, which is the national language. Many participants also spoke English with a variable fluency. More importantly, the vernacular language of conversation is not one specific language. People shift between languages in their dialogue, and sentences in one language are peppered with the words of the other. This perhaps because Urdu itself is a lingua franca that borrows heavily from Persian, Arabic and Sanskrit along with many indigenous languages, and that makes it very easy for speakers to simply borrow words for ideas which have no word in Urdu, from other languages by adding Urdu endings. A close example of this would be Singlish, Hindish, or Chinglish languages spoken in various areas of the world which have cadence and structure of native languages but also borrows words from English (a discussion of Singlish as a creole language, for example, can be seen in Platt 1975, and the recent controversy regarding its use as an part of a uniquely Singaporean identity or as an impediment to education is discussed by Rubdy 2007; Hoon 2003 and Wee 2005).

Linguists (Auer 1984, Clyne 2000) usually distinguish between borrowing (which affects the lexicon of language), and code-switching (which occurs in utterances of the individuals), and both of these processes were visible in the language of my participants. Below I discuss some instances of code switching and borrowing that I recognized.

First is borrowing: Many words of English have no exact (or obscure) Urdu synonyms and they have become part of the parlance to the extent that their Urdu pronunciation would be unrecognizable to many native English speakers (for example,

hospital pronounced as *aspatal*). Secondly, since the medium of education in medical schools is English, Pakistani doctors use a special register of language which heavily borrows English biological and medical terms, and words that are specific to their occupation. For example, in the sentence “*wo mujhe wash up honay ko kehtay hain, sara waqt retractor pakra kay khara rakhtay hain or phir kehtay hain close ker lain*” the words “wash up”, “retractor” and “close” have context-specific meanings referring to different activities in an operation theater (and the translation of these words, even though they are in English, is different from their dictionary definition).

Moreover, I realized that on multiple occasions, code-switching was not just an act of switching between languages, it also interpellated different discourses. It was not just the meaning of the word (referred to as brought-along meaning in studies of code-switching) that mattered, but also the act of code switching that created a specific meaning (called brought-about meaning) (Wei 1998; 2005; Auer 1998). For example, many of my participants spoke of “independence” (usually in the context of women’s rights), which has a commonly used synonym *azadi* in Urdu. They used *independence* when they wanted to situate it in the context of individual rights and freedom which are desirable (hailing the discourses of universal rights as they exist in Western countries), and “*azadi*” when they wanted to point out that reckless pursuit of individuality is destroying traditional structures of family (referring to the idea that being *azad* is dishonorable for women).

Finally, code-switching between languages was also indicative of the various power hierarchies at play in a given situation (for example, between researcher and researched, junior doctor and senior one, man and woman). Many people used English to

assert their authority, social status and class, so I had to be particularly cognizant of the language I spoke during the research process. Usually I took my cue from the participants: If they spoke in Punjabi, I shifted to Punjabi, and if they mixed Urdu and English I did the same. Many participants switched to English when I started recording, even when our earlier conversation was in Urdu because they assumed that I (as a researcher affiliated with an American university) wanted them to speak in English. So I usually specified in the beginning of the interview that I wanted them to speak normally, in whatever language they felt comfortable.

Since early translation of the data can result in loss of valuable information, I decided to transcribe the recordings as they were spoken, retaining their multilingual character. However this proved quite difficult, not to mention expensive, since it required multiple listenings by the transcriber to input Urdu and English text separately. Because of this, not all data could be transcribed. I translated only those quotes which were included in the dissertation, and I have tried to retain the multilingual character of language in these quotes as well, providing actual wording where exact translation was not possible or the poignancy of the comment was lost in translation. Hence, the words in italics in participants' quotes (whether in English or Urdu) are not translated.

#### Analysis: Translating data to meaning

The data gathered during fieldwork included interview voice recordings, transcripts, interview notes, and field notes written during participant observation. Since at the time when I started my fieldwork, various issues of women doctors were being discussed and debated extensively in the media, I also kept track of any discussions on media outlets, social media websites and major newspapers. Although it was because of

transcription difficulties that I initially started voice coding (in MAXQDA), I realized that I preferred voice based coding to text based coding. During the translation of verbal data to written words, many layers of textual data (like pauses, cadence, and emotions) were lost. Encoding the voice recording was time consuming and cumbersome but listening brought back the scene of interview in a way that transcribed words did not. Moreover I was able to better appreciate the emotional saliency of participant's conversations.

The analysis of formal and informal interviews and participant observation was proceeded by identifying themes following a general inductive approach, using the techniques described by Bernard and Ryan (2010). This involved multiple readings of the whole interview, followed by identifying key events, recurring themes, indigenous typologies and silences around certain issues. I also paid attention to the semantic structure of the text and the situated meanings behind the words, where certain assumptions about the world were assumed (Gee 2014). I moved between the interviews, the field notes, and multiple theoretical perspectives to identify any general patterns and trends. Finally, I also took note of silences and taken-for-granted assumptions around certain issues. This was particularly important since, because of my being a doctor and a woman, my participants assumed a shared knowledge of cultural discourses. The verbal filler, "*ap ko pata to hay* (you already know...)" was an important cue for me during interviews and in the subsequent analysis to probe further to understand what was being assumed. Finally I looked for sites of coherence and contestation between various themes with the individual interviews and at the group level. The analysis proceeded in an

iterative fashion. The initial analysis was used to inform the subsequent interviews and to explore theoretically important themes in greater detail.

For example, after reading the data and listening to recordings, I coded the data in main themes one of which was mobility. I then divided this data in further sub themes (like, restrictions in education, day-to-day mobility, journey-to-work, learning to drive, etc.). I then tried to make connections between themes within a single interview (for example, how initial experiences of mobility restrictions lead to difficulty in learning to drive or being independently mobile later in life). I tried to identify broad patterns within groups (for example, is there a relationship between socio-economic status and attitudes about mobility and subsequent access to education and career), and across the groups (for example, how attitudes of family about mobility were perceived by women doctors, and how it affected their individual practices). Moreover, given the interpretive methodology of this study, I did not just focus on the most common themes, rather I tried to explore the heterogeneity of experiences, along with the intersection of multiple factors that resulted in a whole range of practices. Finally, since I realized early on that mobility played an important role in career and educational decision making, I refined and explored these broad themes in subsequent interviews with the participants.

#### Inter-culture Communication: Translating the other

The final instance of translation is writing the analysis and this dissertation itself, and this pertains to both language and meaning. Since I am a native speaker of Urdu, it was easy for me to retain the voice of participant by keeping the data in their spoken language. I only translated the passages which were to be included in the dissertation, as recommended by Corbin and Strauss (2008). Further, since my own training is in English

(both in medicine and anthropology) it was easier for me to code in English. This meant transposing phrases and concepts from one language to another, and from one cultural context to another (Wolf 1997). Since I am writing this dissertation for an English speaking audience, this work of translation occurs throughout the analysis, and at times like any other translated work, it remains imperfect.

I do want to point out the political importance of translation however. By writing about the experiences of women doctors of Pakistan, I am making their experiences and stories visible. Thus they are open to being co-opted in global discourses about Muslim, feminine and Pakistani identity in the ways that my participant did not anticipate and did not intend (Naheed 2008). I am also writing in a medium that remains inaccessible to most Pakistanis (in English, situated in a tradition of academic anthropology). So while I am ostensibly writing critically and politically to provide an avenue of social change, I am ambivalent if this writing remains true to these intentions. This act of translation also makes me complicit in the act of linguistic colonization. Talal Asad (1986, 158) speaks of translation as a discursive process in which ideologies, histories and discourses of “weak languages” of third world, developing countries are colonized by the discourses of “strong languages” of Western countries. In this asymmetric power relation, ideologies inherent in Western languages become the medium through which the “other” of local language is understood (Wolf 1997). The translation process is also rooted in my own cultural history and is a product of social forces that have resulted in this particular combination of languages (Venturi 1986). As I produce and contribute to knowledge in a “strong” language, I am also responsible for weakening and impoverishing my own language.



## **Trustworthiness**

In interpretive research, the usual checks of reliability and validity cannot be used because of its different onto-epistemological foundations (Marshall and Rossman 2014; Schwartz-Shea and Yanow 2013). Here, we do not claim that our data exists in a one to one correspondence with reality. Rather as Geertz (1973) pointed out, the data and subsequent analysis is our construction of meaning making by our participants. Thus, any knowledge claim that we make is necessarily partial and political. Hence, practices of reflexivity, participant validation and intertextuality are recommended in interpretive research (Shwartz-Shea and Yanow 2013).

### **Intertextuality and Crystallization**

Intertextuality refers to the idea that texts and practices can only ever be understood in relation to other texts and the context in which they are produced and understood (Fox 1995). Crystallization, a similar technique but broader in scope (roughly equivalent to triangulation) means relying on multiple sites, methods, individuals, groups and theoretical perspectives to understand meaning making around a particular idea (Ellingson 2009). The result is not a single, uniform “truth” but a more complex, in-depth understanding of the phenomenon at hand, which is still partial and inter-subjective (Haraway 2008; Fraser and Nicholson 2008). To ensure truth worthiness, I interviewed different groups of participants (women, family members and policy makers) with different, even contesting points of view. To ensure theoretical pluralism, I used multiple theoretical perspectives to highlight various aspects of the data. Finally, instead of presenting a homogenizing narrative, I tried to retain the plurality of voices in the participants.

## Respondent Validation

Respondent validation or member checking is another method of ensuring transparency and trustworthiness of interpretive research (Gearing 2004). In this way, a researcher can make sure that she is understanding her participants and interpreting them as closely to their own voice as possible. Shwartz-Shea and Yanow (2013, 100) define reflexivity as a “researcher’s active consideration of and engagement with the ways in which his own sense-making and the particular circumstances that might have affected it, throughout all phases of the research process, relate to the knowledge claims he ultimately advances in written form”. Since I collected and analyzed data in an iterative fashion, I discussed my analysis with participants both individually and in groups. This was not however to force consensus between researcher and participant. As research is an activity of shared meaning making there were some issues where my participants and I did not agree. Instead I used this method to increase depth in my analysis and to understand perspectives of different people as recommended by Barbour (2001).

## (Un)Bracketing the Self

“Why don’t you sit in front of a mirror and interview yourself. After all, you are also a doctor who doesn’t work as one anymore.” (A woman doctor, whom I requested for an interview)

As Pratt (1986, 31) points out, most ethnographies begin with a theme of arrival in an “anthropologist-meets-the-field” sort of story, where an anthropologist encounters a “strange” culture and people and slowly acculturates herself, trying to reduce the distance between self and other. This ethnography however begins with a story of return. I had left the practice of medicine to study anthropology when the issue of women doctors in Pakistan caught the attention of the Pakistani and international media. This issue was

interesting for me not just because I was once a doctor myself but also because, in a way, this issue highlighted a multitude of inequities that Pakistani women faced in their lives.

When I returned to Pakistan, it was to study the women doctors themselves, the very same people who in a way have been my colleagues, classmates, and friends for almost a decade. This somewhat uncomfortable position of being a dual insider, as a Pakistani studying her own culture, and as a women doctor (albeit a former one) studying women doctors, makes it necessary to discuss how my own motivations and positionality affected the research process (Narayan 1993; Jacobs-Huey 2002). The purpose of the following discussion, in which I attempt to locate my “self” in the research project is not to make a claim of objectively superior knowledge; it is to highlight the inherently political nature of knowledge-making. The ethnographic endeavor is a fundamentally intersubjective undertaking, in which subjective and academic selves of researcher and perspectives and experiences of the participants interact to produce knowledge that is partial and fragmented (Jacobs-Huey 2002). The whole process of research, beginning with the questions that we decide to ask and how we position ourselves vis-à-vis our participants is fraught with political implication. This process continues during field work and beyond, as we continually make choices about which narratives and stories to follow, which perspectives to include in writing, the meaning we attribute to our observations and the claims we make about the nature of truth and legitimacy (Candea 2007).

Beginning the fieldwork was very much like coming home for me. Being a Pakistani I was able to understand a lot of cultural cues and silent understandings that are often taken for granted. I understood the nuances of language. I could appreciate what a certain gesture meant, what a particular dress signaled, and what it meant when a

participant lived in a certain area. As a doctor, I had both the institutional memory and professional vocabulary that made my integration easier in the community of doctors. For example, since I had previous experience of working as a doctor, I already knew the rhythm of work in hospital, when a particular unit was working in emergency, when a surgical unit had operation day and when doctors usually took a break. This made it easier to efficiently allocate my time between observing my participants and conversing with them without interrupting them unduly during their work.

There was another side to being an insider however. Since my participants were highly-educated women, many of them researchers in their own right, they were keenly aware of the possible implications of my research. They were also aware of multiple local and global discourses in which their stories can be read and interpreted. As I was a woman doctor myself, asking questions about the experiences of women and raising issues related to gender, raised legitimate concerns and trepidations about my agenda. My participants were apprehensive (and justifiably so) that their stories will be used as an evidence against Pakistani traditions and family norms to provide fodder for the image of Pakistan as an unstable country with a history of violence against women, and used to portray them either as “oppressed Muslim women” or as “rebellious” wives, daughters and sisters who are unfaithful to their traditions and religion. This is why it was important for them to first “locate” me by understanding the research process and my motivations before they could trust me. This is not something unexpected however. In Pakistan, it is usually not possible to engage with anyone in prolong conversation without sharing some information about yourself as a way of locating each other in social landscape. Almost all early meetings with participants therefore began with questions about myself, such as

when I graduated from medical college, which college I attended, why I left medicine and why I chose anthropology. This was usually followed by a detailed discussion of how many participants was I going to interview, what I would do with the data, how I would analyze it and perhaps the most unnerving of them all, will I ever publish a book and who will read it. Needless to say, I did not always have all the answers, and I was slightly uncomfortable especially when questions became personal. However, these questions went a long way to alleviate their anxieties. As a doctor, they immediately identified with me. Many time my interviewees and I discovered we had mutual friends, colleagues, even relatives. This too, helped establish my credibility. Moreover, I was also a married woman with children who lived in a multigenerational home with her in-laws. Sharing these details about my family (even when I was really uncomfortable with it) not only made them easier to discuss their own families, it also spoke of my ideological commitments (that I am not “Western” and a “liberal” who has an agenda against the traditions of Pakistani society).

This role-reversal meant that I always had to be constantly reflexive and self-conscious about the multiple identities I juggled during my fieldwork. Although reflexivity is often understood as turning the mirror onto oneself as researcher, as Robertson (2002) point outs, anthropologists are not the only ones wielding mirrors. Our participants are just as likely to create labels and positions for us. It was especially significant in the case of Pakistan where labels like feminist, liberal, and Western often go hand in hand. As a women researcher, studying women’s experiences, many of my

participants were likely to pigeon-hole me as a “US-returned, desi-liberal”<sup>16</sup> who wanted to tell the same-old story of how miserable Pakistani women are, and how backward Pakistan is. They reminded me, in their conversations and during interviews of how their experiences related to broader discourses of gender and how I was likely to interpret them. It was therefore important for me as part of reflexivity to be cognizant of how my own biases as well as the labelling and interpreting by my participants shaped my project (Robertson 2002).

I employed multiple strategies to address these issues. For one, I sought to include participants from different back grounds and with different perspectives. Instead of looking for a coherent meta-narrative in their stories, I tried, both in the data collection process and later on in writing, to retain the multiplicity of their perspectives. Secondly, I employed participant observation not just as a data collection strategy, but also as a way of gaining the trust of my participants. It made it easier for them to discuss any reservations they had about my motives and for me to be more forthcoming about the research process as I discuss above. To address my participants’ fears about the representation of their stories, I discussed my methodology in detail with them (if someone was interested I provided a copy of my dissertation proposal to them). I told them that even though I may have my own biases, as a researcher it was necessary for me to listen with an open mind, without any pre-conceived notions, and to theorize from their

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<sup>16</sup> A pejorative term which is difficult to define. It is used for someone who is native but utilizes Western discourses for political causes. It can include anyone who speaks of women’s rights, against certain laws and policies (which are seen as Islamic like Hudood Ordinance, or blasphemy laws) and who purports to be secular (as opposed to openly religious).

perspectives. Admittedly, this conversation was a lot easier since the women I interviewed were also researchers and familiar with the concept of bias in research. I also explained to them that unlike quantitative research (with which doctors were most familiar) I am not looking to generalize the findings in search of a metanarrative, I respect every individual's own perspective and meaning making, and I want to preserve this heterogeneity in the reporting of data. I walked them through the coding process and subsequent analysis to further illustrate how data will be translated to writing.

Finally, perhaps the most important strategy was long term engagement with my participants. Although I conducted one or two detailed interviews with all my participants, I tried to remain in touch with them well beyond that. I discussed my findings with them, both individually and in informal social gatherings. If I had a theory, my participants were quick to add their own perspectives, and cite their examples. Many times this led to healthy discussions, and a richer, more nuanced and complex understanding for me.

As I discussed in the previous chapter, in Pakistan, labels like “un-Islamic”, “Western”, and “secular” act as disciplinary devices, whereby anyone involved in the debate on women's empowerment has to create a (narrow) discursive space for themselves by continuously sifting through these competing discourses (Jamal 2005). My participants and I were part of this milieu and we had to position ourselves with respect to the discursive formations in which we were embedded. I vividly remember one such occasion. It was an informal conversation in the break room of a hospital where both men and women doctors were present. The discussion turned to women's domestic responsibilities and the joint family system of Pakistan, with everyone sharing stories

from their lives. Suddenly one of the men doctors turned towards me and said, “Living in joint family system is part of our tradition. That’s how we were raised, it’s part of being a Muslim and a Pakistani. I suppose, with your *amreeki* (American) training, you would write that this system is wrong, that our women should go out and work and leave our elders without care. But this is not our tradition.” In that instant, he simultaneously positioned me as a Western-trained outsider (with a likely western/unIslamic/non-Pakistani agenda) and himself as the sole purveyor of authentic Pakistani tradition and identity, silencing the experiences of other women doctors who may have not quite agree with this version of tradition.

As a researcher then, I had to constantly *work* to be an insider, to legitimize my claim to be *really Pakistani*, and *truly Muslim*, even though my inclusion in these categories was always precarious and subject to challenge, as the incident above shows. It meant that I had to be careful about everything from the language in which I framed my questions, to whether I covered my head, the length of my shirt, and how much English I used in my conversations. These minute things signaled my affiliations louder than my words. On occasions like this, I also had to question my own role as a researcher. Understanding ethnography as a collaborative, intersubjective project, my own subjective experiences are an integral part of my research, but I still had to bracket my own academic self, and suspend my judgement so as not to impose my own biases onto my participants, or worse, alienate them altogether. Remaining silent, and not challenging on the other hand was a source of tension since it made me complicit in a broader structural context and the inequities of power that I was trying to question through my research (Becker and Aiello 2013).



This complicity remained a constant theme for me during research. It meant modifying my appearance and behavior (like covering my head, wearing demure clothes) when it ensured or eased access. It also meant remaining silent when men made sexist jokes or remarks about their colleagues, or discussed whether wife beating is permissible in Islam. Incidents like this, however, made me more attuned to the resistance strategies employed by women doctors in particular. Because the specter of being labelled as a “bad woman” looms large for anyone who does not quite fit the mold of idealized domesticated femininity, women doctors have to maneuver carefully. Instead of employing the rhetoric of universal rights or justice, which would have resulted in them being othered as “Western”, “liberal” and “modern” (Charania 2014), they relied on more subtle techniques of subverting the relations of power in which they were embedded.

Another aspect of being insider is being an insider in more than one positions. During the fieldwork, I was not just a woman doctor researching a woman doctor, I was also a woman, working and juggling family and work commitments like many of my participants. I was also a doctor who left her career as a doctor. My own personal experiences during the medical education and after it are an integral part of this research. These experiences, at least in part dictate why I chose to do this particular project, why I asked these questions and why I worked with women doctors of Pakistan. To that end, this assertion is meant to highlight the partial and situated nature of both the knower and the known. However, while this self-reflexivity was always paramount for me during the fieldwork, it was more difficult to incorporate in writing. How much of my own personal history and stories should show up in the culminating document of the fieldwork, since

they are such an integral part of my research process? Despite giving it a lot of thought, I was unable to find an elegant solution for it.

The ethnographic fieldwork is part of anthropologist's personal history, and to that extent, every ethnographic text is an autobiography: one's description and recall of events shared with others. But despite the reflexive turn in anthropology, the ethnographic "I" rarely makes an appearance except to give legitimacy to an observation. As Okely (2005) correctly pointed out, the appearance of ethnographic "I" at key intervals of an ethnographic monograph, is more of a power trip rather than a practice of self-reflexivity. Even when methodological claims of a self-reflexive anthropologist are usually made, the text of ethnography is usually sanitized of her presence. On the other hand are ethnographic texts that delve extensively on ethnographer's own context and how it shaped the research project, some of the examples being Lila Abu Lughod's (1988) negotiation of her Arab identity and her role of a dutiful daughter in the field, and Ruth Behar's (1995) inclusion of her own and her family's personal history in her ethnography. Both of these texts serve as examples of anthropologists negotiating the difficult terrain between the self and other. The problem arises from the fundamental nature of ethnographic process, where anthropologists translate and make legible "the other" for self. But it is precisely here that native anthropologists, the so-called "insiders", differ. Their mandate is, conversely, to be make their own self (as individuals and as part of a broader identity group) legible for "the other". To that end, my dilemma was closer to what Behar (1995, 67) faced, "What do you do when your parents are 'the other'?" How much leeway I have in recounting my own personal history? Does this give me the right to write "stinky stories"? On one hand, self-reflexivity and the power

dynamics between the researcher and researched demand that I treat my “self” just as I treat the “selves” of my participants: open it up for the (almost voyeuristic) scrutiny, analyses and interpretation. On the other hand, my “self” and my history are not just my own. They are intertwined and related to others, many of whom were part of the research process only because they were related to me, and not because they expressly consented for it.

In the end, the ethical consideration became paramount in how I wrote this research. While “I” makes its regular appearances throughout the text that follows, it is an ahistorical, impersonal “I”, sanitized and devoid of all its connection. My family and my history as a doctor, as a Muslim women living in an extended family and working for her degree do not make an appearance. It is because to my participants I extend the right of privacy and anonymity. I fictionalize their accounts and mask them. I also give them voice, allowing them to speak for themselves, privileging the way they make sense of their world by keeping my own biases in check. I cannot, however, extend the same right to any of the places or persons related to me. By their association, they are immediately recognizable. I realized that unless I make my family part of my study, ask for their consent, obscure their connection to myself and anonymize them, and most importantly, give them voice as I did for the rest of the participants and as they deserve, I cannot ethically write an auto-ethnographic account. Perhaps it is part of my own human weakness, since in my own internal monologue, I privilege my own point of view. Writing about myself, ethically, would have required me to question and confront parts of my “self” which I am unable or unwilling to do. I also could not do what Behar did (1995, 82), keep my writing hidden from those closest to me while exposing them to the

world (writing about care at the same time, no less). I acknowledge that this has resulted in positioning myself as an ahistorical, objective outsider in the text and this is a less than ideal situation. However, this is a small price to pay for prioritizing practice of care in fieldwork.

Finally, to protect the anonymity of all my participants, I have changed their names and the names of major locations. I have also sufficiently obscured the timelines of their stories to prevent identification, without compromising on the coherence of the narrative.

## SECTION 1

### BECOMING A DOCTOR

“Neoliberalism construes even non-wealth generating spheres—such as learning, dating, or exercising—in market terms, submits them to market metrics, and governs them with market techniques and practices. Above all, it casts people as human capital who must constantly tend to their own present and future value.”

(Wendy Brown, Interview by Timothy Shenk, 2015a)

“It is all a business.”

(Qari Sahab, a match maker, about marriage in Pakistan)



Figure 1. An All-Women Practice Class in a Public Medical College

Why are there more women doctors than men in Pakistan's medical colleges?

The answer to this question is simple. It results from a demographic momentum: there is a majority of women in medical colleges because the majority of students who opt for pre-medical track in early education are women. Why medical career and education has become an appropriate choice for women in Pakistan is, however, a completely different question, and the answers I found are not straight forward either.

People choose different educational and career pathways because of complex interactions of multiple reasons. The reasons to choose a particular pathway may be personal: exposure or success in a certain subject during early education, aptitude, identifying with a role model, personal values and expectation of a future life style. Someone may consider an education/career path way appropriate for themselves because

of their socialization and personally held beliefs. On the other hand, availability of educational and career resources, encouragement and advice from families and teachers and cultural barriers also play an important role in educational choice.

It is not surprising that families, particularly families of origin, play a significant role in determining career and education success for women. Attitudes towards education, socio-economic status, advice, expectations and support from families are especially important in Pakistan, where the desirability of medical education for women is one of the reasons why many women students are encouraged to join medicine. The social structure in Pakistan is often described as a “classical patriarchy”, a system of social organization and kinship structure where elder men are usually the heads of their families, and yield substantial social and economic control on everyone else in the family including junior men (Kandiyoti 1988). Women are often given away in marriage at a relatively young age to their husband’s household, where they are considered subordinate to other men and women, especially their mother-in-law (Kandiyoti 1988). Though multigenerational households are decreasing in number, the control exerted through kinship and familial ties still persists. Women are expected to care for not just their own conjugal family but also their family-by-marriage. In Pakistan, although Muslim Family law grants inheritance to daughters (though half of the share granted to sons), few women press for their right in inheritance, and fewer still are given share from the assets like property or land. Demanding these rights would divest women of their share of social capital and kinship relations in their natal home (*maika*), their only recourse in case of abuse or divorce (Agarwal 1997). Thus, as Kandiyoti (1988) aptly puts it, women enter their marriage families as “effectively dispossessed individuals.” This is further

complicated in the case of working women as families of origin and families by marriage often have very conflicting interests in their work. After marriage, it is often women's domestic and reproductive work that takes precedence over their career. Working conditions, support and encouragement thus can change drastically for a Pakistani woman after marriage.

Informal social institutions like families play an important role in the formation of self-identity of any individual. Reproduction of social norms by socialization, and policing of any deviance by disciplining practices is an important function of informal institutions, and families are particularly important in this regard. In this section, therefore, I focus on the influence of families (by birth and by marriage) on educational and career decision making for women doctors.



## CHAPTER 3

### AN HONORABLE PROFESSION: HOW WOMEN IN PAKISTAN CHOOSE TO BECOME DOCTORS

#### **Introduction**

Waqar Hussain has been a teacher in the Biochemistry department in Lincoln Medical College for about 20 years. “This place has changed a lot in these years. There are so many more girls in medical colleges now”, he tells me with a slight chuckle. “I liked it better when there used be fewer girls.” And there are more women than men in the medical colleges in Pakistan. In classrooms, lecture halls and laboratories, women students dominate: some dressed conservatively in *abayas* with hijabs covering their faces, others in more trendy jeans and kurtas; almost all of them wearing a white coat and a stethoscope draped around their necks, universal symbols of the medical profession. Men students are usually a minority, huddled to one side (or in the back, whatever the convention may be).

The contrast it creates with the rest of Pakistan’s education system is striking: Women in Pakistan are less likely than men to ever be enrolled in school. They are also more likely to drop out than men, and during their early education. The overall literacy rates for women are much lower than for men at every age and this differential is even steeper in rural areas. Despite being a little more than half of Pakistan’s population, there are fewer schools, colleges and educational institutions for girls than boys (since public education is segregated in Pakistan), and this difference is greater in less developed provinces like Khyber Pakhtunkhwa and Baluchistan.

So, what makes medicine an exception? Why do women students in Pakistan overwhelmingly prefer to study medicine? An important reason behind this upsurge in the number of women in medical colleges is their increased enrollment in the educational pathways that lead to medical education. As statistics from higher secondary school examination (HSSC) from major educational districts in Punjab show (see, Table 1), the majority of women students who enrolled in science majors, opted for pre-medical education. What makes it more puzzling is that there are no programs or initiatives in Pakistani schools, especially during early education, that encourage women students to enroll in science courses, nor has there been any systemic attempt at career guidance and counseling in Pakistani schools whatsoever. In fact, the government's only response so far to increasing number of women students in medicine is an (unsuccessful) attempt to limit women's entry in medical colleges by re-instating the previous gender based quota.

	Pre-Medicine		Pre-Engineering	
	M	F	M	F
Multan	3139	6728	5924	1976
D. G. Khan	6137	7098	6137	1255
Lahore	6542	18196	14015	5264
Sahiwal	2159	4371	3527	1466
Gujranwala	3863	13454	8420	4127
Bahawalpur	2620	5436	3701	1583
Rawalpindi	1350	4840	5748	2658
Federal	3477	10139	11323	3887

Table 1. Students appearing in HSSC examination in 2015, Punjab, Pakistan

Decision making in education and careers has been a fertile ground for research. This is an important area since the under-representation of women that results from the intersection of multiple social markers (race, class, gender, socioeconomic status, geographical location) in certain educational and career fields, can in part be explained by the decision-making of the individuals: They either self-select out of certain educational pathways, or opt-out of their possible careers. In this chapter, my focus is to explain how the decision to be a doctor transpires for Pakistani women. To this end, this chapter is arranged as follows: First, I briefly review some important theoretical frameworks regarding the educational decision making before highlighting the importance of familial attitudes and cultural influences in Pakistan. I then discuss the importance of the opportunity structure in Pakistani education that forces the students to make educational decisions at a relatively young age, without adequate information about their possible career choices. I also discuss various social and cultural discourses that make medicine an “ideal” profession for Pakistani women. Finally I focus on the narratives of women doctors and their families to highlight how the decision to be a doctor, instead of empowering women doctors, merely reproduces the gendered power relations within Pakistani society.

### **Theoretical Approaches to Decision Making in Career and Education**

Most of the approaches to educational and career decision making are based on the theory of human capital in neo-classical economics, where human actors try to maximize their output by applying to the professions that they consider most suited to their abilities (Hilton 1962; Harren 1979; Bennett, Glennester and Nevison 1992). These models, focusing on *individual* decision making, assume a rational subject (one that is

looking to optimize her choices) but whose decisions are limited i.e., bounded by multiple factors: First, by the information available--a person may not be aware of all the alternative options and their preference may be modified by the way the choices are presented. Second, by their abilities--even when people are aware of the choices, they may not think that they can achieve something. Finally, by the intransitive/unstable nature of their preferences-- a person may not be aware of their future circumstances and their preferences may change as the circumstances change and different priorities take preference during different periods of life (Simon 1982; Gati 1986). Based on this model of decision making, career theorists suggest that the participation and success of students in an educational pathway or career correspond to, or can be attributed to their individual characteristics such as their personal identity (Carlone and Johnson 2007), perception of their sex roles (Schmader 2002; see also Khalid and Frieze 2004 for Pakistani women), confidence in their abilities (Bandura 1977), career self-efficacy (Hackett and Betz 1981; Betz and Hackett 1983; Lent and Hackett 1987; Eccles 1994), and their academic achievements (Eccles 1985).

In contrast to these models, which assume individual free will and free markets (Hodkinson 2008), theorists also acknowledge that vocational decisions are influenced significantly by the interaction between individual and their social environment (Lent, Brown and Hackett 2000). Social cognitive and social learning theories of career choice, for example, highlight the importance of self-regulatory, self-reflective and cognitive process in academic and career choices (Bandura 1977; Lent, Brown and Hackett 2002). Lent, Brown and Hackett (1994) emphasize the importance of dynamic interactions between personal characteristics (predispositions, gender, race and class) and social

context (for example, emotional and financial support, gender socialization, cultural barriers, availability of jobs and learning opportunities).

Another line of inquiry points out the polarization of this body of research, which valorizes either individual free choice or subsumes it completely in social and environmental factors (Okano 1995; Hodkinson and Sparkes 1997; Hodkinson 2008). They assert the importance of integrating these two lines of inquiry and focusing on how individual and structural factors interact and reinforce each other. Hodkinson and Sparkes (1997) for example, building on Bourdieu's concept of habitus, propose that career decision making is pragmatically rational, where an individual's decision horizon is limited by habitus produced through her social environment (34). Patton and McMahon (2006) propose a novel approach towards career decision making based on systems theory, envisioning individuals and their environmental and societal contexts as open systems, dynamically interacting with each other. Similarly Bright and colleagues (2005) point out the importance of chance and serendipitous events in shaping career pathways. Along with a number of other researchers (Law 1981; Osipow and Fitzgerald 1983; Gaskell 1992; Okano 1993), they point out the complexity of human career decision making and the importance of considering a broader range of individual and social factors.

Similarly, research on differential career choices by men and women focus on the complex interaction of gender role perceptions, gender socialization, expectation of success, confidence in one's abilities, relationship of long and short term goals to one's self identity and cost of investing in a career or academic choice (Berryman 1983; Steele 1997; Adelman 1998; Xie and Shuman 2003; Blickenstaff 2005). Although these factors

are important regardless of gender, men and women, through different gender socialization, acquire different self-concepts and achievement goals (Eccles 1983; 1994). For example, they have different hierarchies of their personal values (Rokeach 1973), they place different values on their long term goals (Nash 1979), they consider different activities to be central to their identity and finally, traditional gender roles for women conflict with the demands of male-typed achievement activities (Eccles 1987). Eccles (1994) also points out the role of “important others”, parents and teachers, who consciously and subconsciously undermine women’s confidence in their abilities and provide differential vocational opportunities that drive men and women towards different careers.

### **“Not Really a Choice”: Making Career Decisions in Pakistan**

Although the individual and structural factors that I mentioned above do play an important role in Pakistani women’s decision to study medicine, an equally significant, but often understudied, dimension is the cultural shaping of individual career and educational aspirations. Most research on career choices has been carried out primarily in Western countries, where the underlying assumption is the conception of an individualized personhood, of an individual-in-the-world (Dumont 1986), where choices are primarily made to maximize individual interests and relations to others are secondary considerations (for a detailed discussion of notion of “category of self, see Mauss 1985; and for a discussion of individualism and holism as cultural ideologies, see Dumont 1986). In many other cultures, and in Pakistan particularly, the conception of self is fundamentally different, where self is formed and known primarily within the relation to other (Alvi 2001). This calls for a decision making matrix that takes into account these

different cultural conceptions. In Pakistan multiple social and cultural factors contribute to the underrepresentation of Pakistani women in education and the labor force: Women's status in Pakistan, as measured by indicators like fertility rate, literacy rates, labor force participation and educational attainment, remains low (Jejeebhoy and Sathar 2001). The patriarchal organization of family which gives the male head of the family considerable authority over other household members (Kandiyoti 1988) is backed up by complex kinship structures, rigid gender segregation everywhere from within the household to educational institutions, and powerful ideologies that link family honor to feminine virtue and cloistering. Similarly, specific patriarchal readings of Islamic religious codes, enacted not only by individuals but also by the state in its policies, further cement the unequal gender relations. Education of women, and their participation in labor force is seen as their removal from their "real place", that is, the boundary of their home (Moghadam 1992). Women's work, other than their caregiving roles within the household, is either made invisible or is considered dangerous, immoral, and potentially destructive for the nation and religion (Grünenfelder 2013). This social ideology is further exacerbated by the absence of universal schooling, gendered and unequal distribution of educational resources, and lack of integration of women in workplaces (Alderman and Chisti 1991, Khan and Khan 2009).

Given this background, it is hardly unexpected that Pakistan ranks among the lowest countries in the gender gap index, 144<sup>th</sup> out of a total of 145 (World Economic Forum 2015), with only 25% of women above 15 years of age formally employed (The World Bank 2014a) and a female literacy rate of only 43% (The World Bank 2014b). This makes it all the more surprising that so many of them choose to be doctors in first

place. Decisions to adopt an educational pathway or a career do not usually take place in a certain moment. Aspiring towards a career means envisioning a road map of sorts towards attaining a certain goal or target, with an implicit suggestion that a person exerts some effort to achieve that goal (Bok 2010; Prodonovich, Perry and Taggart 2014). However, as Appaduari (2013) suggested, aspirations and the capacity to aspire towards a certain goal are social and cultural products. Hence, the aspiration towards being a doctor that culminates in the decision to pursue the pathway of medical education is not entirely an individual preference, or a byproduct of structural constraints. Rather, it is formed in the “thick of social life” (Appadurai 2013, 187). Why a certain educational pathway or career is considered normal, acceptable or (as it is the case of medicine for Pakistani girls) highly desirable, reveals a lot about the cultural model of success upheld by a society (Kim 1993, Louie 2004). Since the resources that lead to, and support the educational and career aspirations are not evenly distributed, the capacity to aspire is similarly unevenly distributed. Students with certain social markers (gender, class, race, geographical location) may find it impossible, abnormal, or unacceptable to even dream about certain careers, let alone decide to pursue them in reality. Finally, aspirations and decisions also depend on the road map and pathways of education available to a student. Hence the structure of education, and the version of choices it offers to the students also directly affect their decisions (Appadurai 2013).

In the discussion that follows, I first examine the layout or map of Pakistani education and how restricted lateral mobility and gendering of scientific disciplines contributes to the desirability of medical education for women in Pakistani society. I then examine the narratives of participants and their families to understand why they chose to



be doctors, and relatedly, why medical education has come to be considered desirable for women in Pakistan.

### **A la Carte: Opportunity Structure in Early Education in Pakistan**

One the most significant factor in the career choices of young people, especially girls, is the structure of education itself. In Pakistan, the decision to choose a discipline or a subject to study and a career to pursue in the future has to be made very early in the educational process. A student has to choose at the end of eighth grade (when she is 12 or 13 years old) if she wants to study sciences or arts, and at the end of tenth grade (when she is 16 or 17 years old) if she wants to study biological sciences in college to become a doctor or non-biological sciences (mathematics, physics, chemistry, computer sciences) to become an engineer. In most Pakistani schools, these are the only available routes. There are often no other courses or career pathways available for students to explore before they can decide.<sup>17</sup> More importantly, the decision has to be made *before* one has the chance to take any initial courses in the subject. Therefore, if after a year or so, a student realizes that she does not like a particular subject, or does not have the aptitude for it, the only way to change her educational pathway is to start that particular grade all over again, which wastes time, effort, or money that has already been invested. After the 10<sup>th</sup> grade, students are awarded a “secondary school certificate,” also called matriculation (matric, for short). After that, students get admission to a college based on their performance in the matric for a “higher secondary school certificate” commonly

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<sup>17</sup> This is true of the public education system in Pakistan, where a majority of students study. However, there are other parallel education systems in Pakistan which may offer more choices, which I will discuss later in the chapter.

called F.A (Faculty of Arts) or F.Sc (Faculty of Sciences) depending upon the course of study a student chooses in the matric. After two years of college (11<sup>th</sup> and 12<sup>th</sup> grade), most students try to gain admission to a professional college. The medical colleges choose from the pool of students who have completed F.Sc (pre-medical) while the students opting for pre-engineering are selected by the engineering universities (Figure 2).

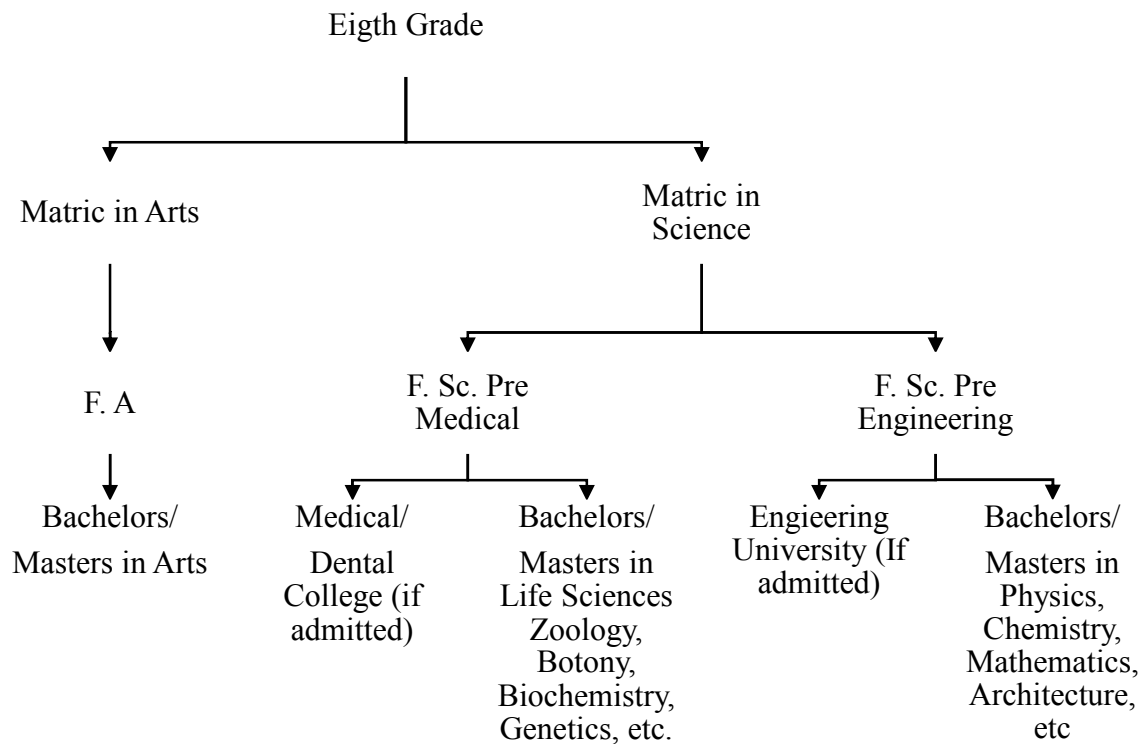


Figure 2. Structure of Early Education in Pakistan

Science education has often been theorized as a “pipe-line” which leads students in a more or less linear pathway from science courses in school to college and then possibly to a higher degree in science and a job (Berryman 1983, Blickenstaff 2005). Even though scholars have problematized the use of this particular metaphor (Xie and Shuman 2003), since it does not address the lateral mobility in education pathways, in Pakistan, science education *is* a pipeline. There is little to no lateral mobility possible especially in the public education system. Someone who has opted to take the science route in the matric will not have the opportunity to take any courses in social sciences, linguistics, history, or any subject other than mathematics, physics, biology, computer sciences and chemistry until much later in their educational career. Similarly, someone who has opted for the pre-medicine route in F.Sc. will not have the opportunity to study computer sciences and mathematics until much later, and then only by foregoing the pre-medicine route completely.<sup>18</sup>

Such a rigid and linear education structure with limited choices has multiple consequences for students. For one, most students have to make these decisions at a very early age, with little available information. Even though career counselling and guidance play an important role in providing information to students making important educational choices, there are no facilities for career counseling available in most Pakistani schools. Students depend on their peers and families (and in very few cases, their teachers) to

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<sup>18</sup> Even though this opportunity exists in theory, it is much more difficult in reality. The college level courses require the knowledge of intermediate level courses, so those who are “changing the track”, so to speak, often have to complete the intermediate level courses in order to take admission, increasing the time and cost burden manifold.

guide them and women students as I discuss below are almost always advised to choose medicine. Usually, young students don't have the required information to make their case in front of their parents about any other pathways that may or may not be available, and even if they do, their opinion or choice is often attributed to their youth and immaturity and mostly disregarded. Similarly, it becomes difficult for both students and their families to choose against the norm. Many participants were advised by their parents to choose medicine because this was what most of their peers were doing. Finally, given that the Pakistani education system does not allow for lateral mobility, once that decision is made, it is very difficult, nearly impossible even, to change it. The decisions made about one's career or education at this point create a path dependency which continues to affect that person for the rest of their life.<sup>19</sup>

### **“My School does not Teach Science”: Intersections of Educational Structure in Pakistan**

Constraints on educational and career choices are not uniform for all students. Intersections of gender, class and geographical location (urban or rural) make the available choices even more restricted for some of the students. For example, in most parts of the country, there are fewer schools for girls than boys, at every level of education (Latif 2000). If families are not willing, or unable to send their girls to a distant school, their dreams for further education are shattered. Even when they are present, not all girls' schools offer science courses, which can seriously limit the career and education

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<sup>19</sup> It should be noted at this point that these circumstances are same for men and women, the only difference being that the parents are usually open to men being either an engineer or a doctor, and to this extent, they have a little more choice.

opportunities available to girls. As a result girls' enrollment in science majors is lower in rural areas as compared to large urban centers (though the majority of them still prefer pre-medicine), and there are fewer women doctors in Pakistan's less developed provinces. Selma, a 34 year old doctor, completed her early education in a small village of Punjab. Her elementary school was a *Taat wala school* (a school which did not have furniture for students to sit on, so they sat on floor or on mats, literally, a school with jute mats). Students sat on the floor and practiced writing on *takhti* (wooden tablets). She had the highest marks in 8<sup>th</sup> grade but there were no teachers at her school to teach science. So, she had to arrange for private lessons, as she described:

In those lectures when other students studied arts subjects, we sat in the back of the class and read a novel, or worked on our laboratory journals. The (man) teacher who taught science in boys' school had opened a tuition center and when the school ended, we went there for two hours to study mathematics, physics and chemistry. Then, there was no college for girls in our village, so I went to a college in the city nearby and I had to stay in a hostel there.

These gendered restrictions continue to affect women throughout their education. Families may also be unwilling to send their girls to a distant college, with better educational facilities, since it usually means that they would have to live in a hostel, away from their families, where supervision and social control of the families is potentially weak. Many of my participants had to attend a college closer to their homes, even when they were eligible for better (but distant) colleges. Raheela a 36 year old doctor, for example, recounted how she originally got admission in a medical college in another city. Her family used their political clout to arrange for her to move to an all girls' medical college that was in her own city and where she did not have to live in a hostel.

Therefore, even when women have equal access to educational facilities *in theory* other structures of the educational assemblage restrict their access *in practice*. Overall lack of infrastructure (fewer educational institutions for women, lack of gender parity in the availability of facilities, like hostels and transport to educational institutions), and social and cultural norms all played a part in restricting available educational and career choices to women. For example, even when a girl gains admission to a prestigious educational institution, it does not necessarily mean that she will be able to attend it. One family recounted how their daughter got admission to a prestigious private university. However, that university was in another city and unfortunately did not offer residential facilities like hostels for their women students. Though there were privately owned hostels for girls in that city, they were deemed unsuitable because they did not provide enough “security” to the residents. That is, they did not maintain strict curfew hours and allowed unrestricted visitors without checking with the girls’ families. Only when a nearby family of relatives allowed her to stay at their home for the duration of her degree was she permitted to attend the university. Needless to say, letting a young woman live alone, on her own, in another city, was simply out of question.

Similarly, as I mention above, geographical factors can also affect the educational options available to women students. The situation is especially worse in rural areas that are far from urban centers and in less developed parts of the country like Southern Punjab, Khyber Pakhtunkhwa and Baluchistan (Latif 2000). In these regions, public schools (when present) are often not well equipped and ill-staffed. Although poverty does contribute to these differentials, at least part of the reason is the unequal distribution of resources by the state, which directly affects the educational options available to rural

students, especially girls. Hence, women living in rural areas are often at the bottom end of this spectrum, with the least access to education facilities.

Similarly, the socioeconomic and class status of the students can remarkably change the choices available to them. Students who come from lower socioeconomic backgrounds are particularly vulnerable to a less favorable distribution of educational resources because they rely much more on schooling for information and skill building, especially when they are the first in their families to aspire to higher education. In comparison, their peers from the higher or middle class often have multigenerational knowledge, an “educational memory” and resources of navigating the educational system (Bok 2010; Prodonovich, Perry and Taggart 2014). Although the relationship of class in determining educational attainment is well established (White 1982; Kao and Thompson 2003; Sirin 2005), this disparity is further exacerbated in Pakistan by the fragmented and highly classed educational system. Apart from the state managed public education system, which I described above, there are several parallel education systems in Pakistan. For example, students who are studying under the Cambridge system (and who generally belong to affluent families) can choose courses in mathematics and biology simultaneously, which is not possible for students doing F.Sc. under public education system. A medical student, for example, commented on his choice to do A-levels instead of F.Sc:

I chose A-levels because it gave me the freedom to study Maths as well Biology, which is not possible in F.Sc. I did this as I still had not decided whether to become a doctor or to go towards the engineering side. This gave me 2 more years to decide on which career path I wanted to be on [sic]. But truth be told, I still don't know why in the end I chose MBBS over engineering. Perhaps a little bit of parental pressure and the job security of doctors played a little role in my decision to join the Doctor's

Side. I'm still conflicted over this decision... (Ahmad as quoted in Ali 2016)

Moreover, these private schools (which are not using public curriculum) often offer a greater variety of courses in multiple subjects (not offered in the public education system), and relatively more flexible course choices, opening up multiple (and more interdisciplinary) career pathways.<sup>20</sup> But most of these schools and colleges are present only in large urban centers. Also, since these institutions charge exorbitant fees, Rs. 15,000 to Rs. 30,000 (approximately US\$150 -\$300) per month as compared to the nominal fees charged by the public schools, they are all but out of reach for most lower-income Pakistani students. These differences further intensify the choice gap between students. Because of these multiple factors, women students belonging to urban, well-educated, upper to middle class families, who have better access to educational facilities, have a much better chance to get admission in medical colleges.

### **“Girls don’t do engineering”: Gendering the Scientific Disciplines**

Such limited opportunities for children from rural and poorer families become even more limited for women because of social perceptions about various scientific disciplines, which makes women more likely to study life sciences, especially medicine in contrast to other scientific disciplines like engineering. There is a strong perception in Pakistani society that the only professions suitable for women are education or medicine

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<sup>20</sup> Such institutions often consciously focus on a more transdisciplinary approach. A professor at one such institution (a private university) for example, told me that every computer science major at his university is required to take basic courses in biology, chemistry and humanities, since, as he explained, “you never know, someone might want to do computational biology later on.” This approach is unheard of in most public colleges and universities.



and other professions, especially engineering, are not suitable for them. A member of Pakistani Senate, for example, commenting on Harassment of Women at Workplace Bill on national television argued that only two professions suitable for women are teaching and medicine, and that even these professions should be adopted only if absolutely necessary (Ebrahim 2010).

One reason behind this cultural perception is that these professions (teaching and medicine) align with the culturally acceptable roles of women of caring and nurturing, as they are seen as an extension of women's domestic roles. This is especially important since education for women in Pakistan is often "marketed" along their accepted gendered roles. For example, it is stressed that educated women make better mothers, or that educating a woman is educating the whole family. Another reason, as I discussed in the history of medicine in South Asia in Chapter 1, are cultural practices related to purdah and modesty. The institutionalization of these purdah related discourses in the form of women's only hospitals (during colonial time) and a gender segregated school system (that continues to date) created a demand for women teachers and doctors to cater to the needs of women students and patients; and marginal cultural and religious acceptance of women in these roles (Grünenfelder 2013).

As I mentioned above, a majority of women in scientific disciplines across the world are concentrated in biological and life sciences. Ecklund, Lincoln and Tansey (2012) found that certain disciplines (biological sciences, for example) are considered related to emotional and affective labor, and thus more feminine. Scientists themselves believed that women preferred and/or excelled in these fields either because of their innate abilities or because of innate preferences. Thus, women scientists were often

discouraged from entering physical sciences, and faced greater discrimination from their colleagues and seniors if they did (Cech 2015).

Although a similar pattern exists in Pakistan, it is because of entirely different social and cultural reasons, which often had nothing to do with the conception that men and women are naturally better in certain fields. Rather, it is because the cultural definition of an “ideal career” for men and women is different. In Pakistan’s patriarchal system, where the honor of the family is tied closely to the conduct of women, an “ideal” career for women is one that conforms to the norms of feminine behavior expected of women. That is, it ideally does not interfere with the domestic responsibilities of the women, and it does not involve frequent contact with opposite gender (and thus conforms to the requirements of modesty and purdah). Fazeela, a doctor herself and the mother of a woman doctor, for example, explained why she preferred medicine for her daughter:

One has to work really long hours in engineering and other professions. An engineer will have to leave for work in the morning and usually won’t come home till 8 at night. I have seen women who work in banks, or in companies, sometimes they have to stay out all night. How can a married woman, a woman with children and family keep up with those timing?

This comparison may not be seem entirely accurate, since medicine has an equally (if not more) erratic work schedule than any other profession. However, as Fazeela explained, in contrast to all other STEM career and education pathways, medicine allows for maximum career flexibility (that is, you can put it on hold for long periods of time), and in medical career one can (at least theoretically) choose the schedule one wants to keep by opting for the less time intensive, family friendly specialties:

Medicine is preferred because you have a lot of choices. Sure you may not be able to be a surgeon, but you can do a nine-to-five job in many other specialties, radiology and pathology for example, where you don't have to do duties at night, or handle emergencies. You can become a teacher in any of the medical colleges. It pays well and the schedule is not too bad. And even then, if you have to leave, if you cannot continue, you can just take a break and come back anytime. A doctor is always a doctor. You can start your own private practice. I know a doctor who started practicing medicine again at forty years of age, after her children were all grown up, and she did her specialization. You can't do that in any other profession.

Similarly, even though the structure of hospitals has changed significantly after partition, and completely gender segregated hospitals of the colonial era no longer exist (since in Pakistani hospitals of today, a woman doctor has to work with men patients and a doctor cannot refuse to see a patient because of their gender), the cultural concept that women doctors work to serve primarily women patients still continues. Because of this cultural ideal (that women professionals are serving only women in their own separate sphere), medicine is considered an ideal profession for women. This idea is further cemented by the particular structure of medical practice in Pakistan that allows women to work as independent healers<sup>21</sup>, as Raheela, a 37 year old doctor who practices in her own private clinic, explained:

In engineering you are dependent on men, you have to work with them in one capacity or another. You have to get out and work in the field. In medicine, even if you are not working in a regular job or in a hospital, you can open a clinic in your own home, like I have done. You can only see women patients. You are independent.

Hence, a career considered “honorable” for high-educated Pakistani women is one in which she can avoid working with men, can keep flexible hours, and which can be put

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<sup>21</sup> I discuss this aspect of medical practice in Chapter 9.

on temporary hold because of family demands. In Pakistani consciousness, it is “being a doctor” that fits the bill. More importantly, this cultural gendering of scientific disciplines works both ways. On one hand, it has made medicine the pinnacle of achievement for Pakistani women. 23 year old, Rafia who is doing her house job, for example explained her passion for medical education: “I felt at that time that medicine is like *miraj* (literally ascension to heavens), and if I could not become a doctor, I am so worthless that I should commit suicide.” On the other hand, it also discourages anyone who has chosen (or wants to choose) other career pathways. A women student of engineering, for example, shared how her relatives commented on her choice to be an engineer, “Oh poor you! You are studying so hard, and it is all going to waste. My child, why didn’t you become a doctor? (*Hai hai! Ina parh k vi zaiya e kita. Putar doctor e bun jana si!*)”

In the analysis of career decisions and aspirations, the structure of schooling is especially important since education provides a road map to students for their future aspirations. Thus, when students have to choose from a fixed array of available educational options, with the understanding that other paths are not for them, it essentially limits their future aspirations to the “ideal” of a medical career. Part of the reason why so many Pakistani women choose the medical profession is because the structure of early education in Pakistan, along with associated social and cultural values, limits their entry into other career pathways. This is a classic example of what Bachrach and Baratz (1963) call a non-decision, where the possibility of a choice is effectively removed by limiting what a person believes possible, desirable or normal. While it appears that Pakistani women are choosing to become doctors, their choice is merely an outcome of social and cultural constraints on their educational decision making. This

drives students and their families towards the cultural schema that “being a doctor” is the ultimate achievement and career “choice” for a woman.

### **“An Intelligent Girl should be a Doctor”: Familial Influences on Educational Choice**

The reason I wanted to be a doctor was those sari-clad doctors in army medical corps (laughter). My father was in the army and I was really inspired by them. At that time I thought a doctor is someone who wears a sari, gives injections and does surgical operations, so I wanted to do all of that. Because medical profession is so respectable. At that time in 60’s and 70’s, women doctors were even more valued because there were so few of them. King Edward Medical College used to admit only five girls. So it was a *trend* that if a girl is intelligent and she excels in her studies, she should be made a doctor. My mother also really wanted to be a doctor herself. She even had enough mark for it. My grandfather did not allow her because he didn’t want her daughter to study through co-education with boys. He said that even if she studies in an all girls’ medical college, she will still have to work with men. It was (a combination of) an unfulfilled wish of my mother, and because I really liked those sari clad doctors. (Beena, 37 year, surgeon)

When I asked my participants, ‘Why you decided to become a doctor?’ there were no simple answers. The above quotation from Beena, who is a surgeon now, exemplifies the complex reasons behind the decision to be a doctor. Inspiration from powerful social images like women doctors in the army medical corps in their graceful uniforms, cultural acceptance of women’s role as healers and doctors, the honor and respect accorded to medical profession and preferences of family, especially parents, all played an important role in the making her a doctor.

It is interesting to note that most models of educational and career choice that I discussed above have the underlying assumption that despite all structural and institutional factors affecting the choice, it is essentially the individual who is making that decision. Despite the influence of families on the individual educational and career aspirations (Bratcher 1982; Fan and Chen 2001; Hargrove, Creagh and Burgess 2002;

Louie 2001), it is assumed in research on educational decision making that it is the individual who ultimately makes the choice regarding her future aspirations. However, in Pakistani society, particularly in the case of women, the decision-making parameters are very different. Studies indicate that, even when they are in other countries, Muslim Pakistani women are heavily influenced by the expectations of their families (Knox 1992; Basit 1996). In Pakistan, the educational decisions of all students, not just women, are to a large extent governed by their families and social expectations, as I outlined in the previous section. For one, it is the families who control the economic resources which determine the educational and career aspirations as well as their actual attainment. Unlike western countries, where students have (however limited) options of scholarships and student loans, most educational institutions in Pakistan do not offer such economic support. Similarly, students in Pakistan do not work or earn money during their education, mostly because there are limited jobs available for them, but also because of a strong cultural norm that it is the obligation of the family to provide for an education. Secondly, in Pakistan, education and career aspirations are not seen as entirely individual decisions. Rather they are viewed in the context of present and future wellbeing (both material and in terms of status and prestige) of the whole family (Knox 1992). This makes the career decision-making a group process instead of an individual one, where each family tries to optimize their social, economic and cultural capital within their given resources. This is especially relevant for the girls who are socialized from a young age to think and decide within the context of family responsibilities, present and future, rather than individually, for themselves (Gaskell 1992).

For a majority of participants, the decision to be a doctor was either made by their families or it was heavily influenced by them. A typical answer to the question, “Why did you decide to be a doctor”, often started with “Well, I was young and I didn’t know anything. I had good marks so my parents told me to be a doctor.” As I discussed earlier, students often had to make these decisions at an age when they were often considered not mature enough to decide for themselves. This assumption of immaturity was often shared by the students (who have limited information about educational pathways and thus are not confident enough) and encouraged by the families, who are trying to ensure that their children achieve what is their version of “a good life” (Appadurai 2013, 187). Arshia, a postgraduate trainee in gynecology, for example, explained how she became a doctor because of her father’s strong wishes:

Students are immature and young in the matric when they have to make this decision. Most of the people who are doctors chose this profession to fulfill their parent’s wishes. My father had a strong wish to make all his kids doctors, now three of my siblings are doctors. It was drilled in our brains that we have to be doctors. We had no idea what happens in medical education. If a person knows how difficult it is, they probably wouldn’t choose this profession. But we just wanted to fulfill our parents’ wishes and be a good doctor.

Sometimes, this decision was precipitated consciously or unconsciously by an unfulfilled wish on the part of the parents. It was usually mothers (though sometimes fathers too) who had wanted to be a doctor themselves, and either because of cultural restrictions (like Beena’s mother) or financial and geographical constraints (like Farhat’s mother) they could not achieve their goals. In a way, they lived their dream through their

daughters.<sup>22</sup> Hania, a postgraduate trainee in radiology was similarly inspired by her father to be a doctor, as she explained:

In fact it was my father who really wanted me to be a doctor, but I was also interested. I was good in science subjects from the beginning. My father wanted to be a doctor himself. But he couldn't get admission to a medical college because of his religion in colonial India. So he studied biology and went in government service. When he migrated to Pakistan, he went into accounting. My brothers were not interested in sciences either, they also liked accounting and finance. But I was interested from the beginning in medicine so he encouraged me.

Similarly, Farhat, a medical officer in pediatrics described how her mother's version of "a good life" as an educated, respected person was instrumental in her decision to be a doctor:

It was my mother who really wanted me to be a doctor. Because she herself was not very educated, she had studied only until the 8<sup>th</sup> grade. My parents are the kind of people who are not educated themselves but they really want their kids to be educated. We migrated 25 years ago from our village, just to provide better schooling for me and my siblings. I think I became a doctor because of the *respect*, and because I *idealized* the profession a little.

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<sup>22</sup> This raises questions regarding the motivation of women doctors about their education and career. Writers have been quick to point out that women join medicine to appease their parents, and since they lack motivation to fight for their career, they leave as soon as they are married. This is rather a simplistic claim that is not backed by any research. Though studies from Western societies indicate that parental control is associated with lack of motivation, stress and other negative effects in students, results from other interdependent cultures, where group norms favor collective decision making, are different (Marbell and Grolnick 2012, Hagger, Rentzelas and Chatzisarantis 2013). My own research suggests that with few exceptions, women's exit from workforce was a complex issue, and the role of parents should best be identified in the context of each specific case.



Farhat's mother's account of this decision is similarly poignant. It shows the sacrifice she made for her family when she was young to give up on her educational dreams, and how it translated in the strong desire to invest in her daughters' education:

I always wanted to be a doctor myself, but my mother died young, and I was the eldest taking care of my younger siblings. I couldn't leave them to go off to medical college. So you can say that it was my wish. But it's not as simple as that. It might be your wish, but you have to think of your resources, and what options are available as your kids grow up. We didn't know of any other option. We just thought medicine is the best.

Iffat, a postgraduate trainee in gynecology similarly recounted how her mother not only strongly advised her to select medical education, but also pushed her to choose gynecology as her specialty. When I asked Iffat's mother the reason for her preference, her response indicates how her own personal experiences motivated her desire to encourage her daughter to not only be a doctor, but also an agent of change in her profession:

When I had my kids, the doctors who treated me during pregnancies were just rude. They did not listen to me, even rebuked me if I cried in pain. One of them told me, 'What is your problem? You start crying whenever I start eating. You are not even letting me eat my lunch in peace.' It was humiliating. I thought I would make my daughters better doctors and better human beings, so other women are treated better than I was.

For other parents, job security and financial rewards were also an important part of "a good life". Although generally women are not expected to work, or to contribute to family income, most parents recognized that in current economic situations, it could be difficult to maintain living standards if only one person is earning. To that end, medicine seemed the best career for their daughters because, as discussed above, it complies with the gendered cultural norms associated with women. Especially in the particular family structure of Pakistan, where women often have no financial recourse if their husband

decides to divorce them or dies, professional education acts as failsafe of sorts, allowing women to support themselves in case of such eventualities. Kalsoom, a gynecologist, told me she always wanted to be a doctor, “My mother has recordings of me from my childhood in which I am introducing myself as Dr. Kalsoom.” She went on to explain:

My mother always wanted me to have a professional degree, where I could work and earn. Not that I *have* to, but that I could support myself in case something happens. My uncle died young and he had small kids. His wife was well educated, she had a graduate degree, but after the death of her husband she couldn't get a job. They had a really tough time. Relatives and family can only help so much, you know. This really affected my mother. She didn't want any of that to happen to us.

It is interesting to note that parents often maintained that despite their heartfelt wish, they gave the complete right of decision to their children. Children, however, did not always share this view. They realized that they were being pushed towards a certain career path, and that they have no choice but to follow. Saira is a medical graduate from King Edwards Medical College. All her siblings, two younger sisters and an older brother, are also doctors. Her father, born in a village in rural north Punjab, walked to another village every morning for school. When I asked him why he encouraged his daughters to be doctors, he explained:

I wanted to be a doctor, but my family did not have enough money to send me off to a hostel in another city even though I had good grades, so I had to choose another subject. When I had kids of my own, I vowed that this will not happen to them. They will not be held back because I do not have resources to support them. So I went to all lengths to help them achieve what they wanted. I did not push them to be doctors. I may have told them that medicine is a good profession like all parents do, but I did not force them to choose it. But once they made their choice, I helped them in every way that I could.

When I put the same question to Saira, however, she replied simply, “Because my father wanted to be a doctor, and he couldn’t be one himself, he pushed every one of us towards it. He made all of us doctors, all three daughters and a son. It was his wish.”

It must be noted that this is not simply a form of coercion on the part of parents, nor is the decision always forced upon the children (though sometimes it is). Usually, parents and other family members consciously or subconsciously start planning the medical careers of their kids from a very early age, and they continue to subtly (and sometimes overtly) suggest it to them. Since the students themselves often have had no exposure to any other possible options (courtesy of the structure of Pakistani education), they are happy to go along with their parents’ suggestions. Although the actual time they make their decision is much later, most families (especially educated, middle to high class ones) start asking this question from their children from a very young age, “What do you want to be when you grow up?” and even start suggesting possible careers.

At other times, these suggestions are more overt. Even when students wanted to join other professions, their parents strongly suggested that they join medicine.

Memoona, one of my interviewees who was a doctor, for example described how she picked pre-medicine as an educational track:

I loved engineering. My father was an electrical engineer. Whenever someone asked me in my childhood, ‘What do you want to be when you grow up?’ I always said that I am going to be an engineer like my father. But when the time came to decide my family suggested that I should choose medicine. They said, ‘All your friends are going in pre-medicine, so give it a try. And if you don’t like it after a month or so, you can change and study Mathematics instead.’ But after a couple of months I adjusted and found biology to be okay, and I became a doctor.

I should stress here that I am not trying to portray families as the proverbial “oppressors” who overrode the will of their children and took away their agency. Parents pushed their kids towards a medical education because they believed it would lead to a successful and financially secure career, because they were trying to optimize their girls’ chances of moving up the social and economic ladder and because they believed that, given the social parameters, a woman doctor has the best chances of actually *working*. In that sense it can be considered a “pragmatically rational decision” by them (Hodkinson and Sparkes 1997). However, in doing so they intentionally or unintentionally re-entrench the gendered basis of differential career selection. Saqib, father of a young woman doctor, for example, explained why he didn’t let his daughter study physics (which she preferred) and steered her towards medicine instead:

My daughter really tried to convince me to let her study physics. She was genuinely interested, we could see that. But at that time, it seemed like a headed-to-nowhere decision. What was she going to do after she studied physics? Say she gets a masters, what will she do with her degree? Teach somewhere and that is only if she is lucky with the situation of jobs at universities these days. There are no research opportunities for people in physics in Pakistan, not even for boys. We certainly couldn’t afford those fancy private universities. But a degree in medicine, she could actually do something with it. She could work.

An important consequence of this arrangement is that it takes a purely instrumental view of education, only as a means to an end, a preferably well paid career, secure income, and social status. It ignores other goals of education and schooling, like learning, skill building, knowledge production and social change. It also ignores that education can be (and should be) fueled by curiosity and a desire for knowledge, rather

than demonstrable results and returns.<sup>23</sup> Naima, a 53 year old medical specialist, became a doctor because of the strong wishes of her own mother. Now a mother herself, she has strongly encouraged both her daughters to be doctors. I met her and her husband over a cup of tea in their home. When I asked then why they preferred medicine for their daughters, she explained:

I felt that I have to make sure that both of my daughters are doctors. I felt that an educated girl is a doctor. My younger one always wanted to be a doctor but my eldest wasn't much interested. She was really good in her studies though. She had an aptitude for fine arts. She was really good in drafting, designing, and painting. Her teachers told me to send her to National College of Arts. But I wanted to send her to medical college instead and she didn't resist at all.

Her response indicates how women who go into medicine because of their family pressures then reproduce those pressures for their children in the next generation. It also indicates how forcing women to choose a profession against their aptitude later on contributed to their “leakage” from medical workforce. Their eldest daughter moved abroad after graduation, and eventually left the medical career altogether, getting more involved in designing and crafting.

Although for a majority of participants, families played a deciding role in their career selection, either overtly or subtly, the discussion above is not meant to show that

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<sup>23</sup> Though that is a debate in itself, which is beyond the scope of this chapter. After all major funding agencies also require research projects to demonstrate some practical, broader merits beyond the natural curiosity. This might be seen as an extension of “economization”, the universality of market rationality permeating every aspect of life. As Wendy Brown (2015) points out, this is not simply a process of monetization, rather “neoliberal rationality disseminates the model of market to all domains and activities—even when money is not at issue—and configures human beings exhaustively as market actor, always, only, and everywhere as *homo oeconomicus*.” (31)

women were hapless beings facing the indomitable will of the social structures surrounding them. On the contrary, it is to emphasize the underlying basis of the power differential that makes this arrangement possible: that parents have sufficient authority over their children to make them go along with their decisions and the children must be willing enough to submit to their parents' choice. Though socialization and financial resources give unequal bargaining power to the parties involved, it does not drain the women as young daughters completely of their negotiating ability. Below I discuss a few examples that illustrate how women occasionally went against the express desires of their parents, manipulating them to go along. However, I must note here that these manipulation strategies worked because even though by asserting their own educational decisions women were defying their parents' wishes, they were reproducing and reasserting the social norms of respectable career for women. Naila's story is especially interesting. Her mother, a successful working woman herself, was not only against her being a doctor, but also against her having a career at all:

When I told my mom that I want to be a doctor, she told me it is a very difficult career, I would need to study a lot and that I should not opt for this, and go for something simpler and easier. It's really surprising because most parents encourage their kids. Perhaps it was because my uncle was also a doctor and she had seen his career, and she knew it would be difficult. It was also because she was a working woman herself and she wasn't in favor of the girls having a professional education and a career, because her own experience of managing a home with a full time job has been difficult.

Despite her mother's opposition to the idea, Naila's uncle, a doctor, encouraged her, and helped her with admission. Her mother eventually accepted her decision, though as Naila told me, laughing, her mother never misses the opportunity to say, "Told you so" whenever she is feeling frustrated with her job. Naheed, another woman doctor, described

how her father was unwilling to let her become a doctor. Creatively using the social discourse of “every intelligent girl should be a doctor” she managed to persuade her parent to go along with her choice:

I really wanted to be doctor, I don't know why. May be it was because each and every one of my friends were going for it. Or it was because it was understood at that time that if someone is a good, intelligent student she has to be a doctor. My father wanted me to follow his footsteps and study chemistry. He said, 'Your elder brother and sister are already becoming doctors, you should go for something different.' He really pushed me for it. I even started taking classes in pre-engineering track. But I was not happy. So one day, I went home and I just started crying, saying why are you not letting me be a doctor, I get good marks too, I have stood first in every class like my elder brother and sister, and this is really unfair and unjust that you are not letting me be a doctor like them. Instead you are forcing me to study chemistry like my younger brother who wasn't very good in his studies and he was doing bachelors in physics. So you think I am *nalaiq* (unintelligent) like him? So my mother eventually relented and said, 'Please don't cry, you can study whatever you want.'

### **Is Education Really Empowering?**

Narratives that I discussed above highlight multiple dimensions of educational and career choice for Pakistani women. As Appadurai (2013) asserted, future aspirations, even the vocational ones, are made and acted upon within the milieu of existing social constraints which determine what is possible, normal and desirable for any given individual within a society. The structure of the Pakistani educational system, different and gendered definitions of ideal careers for men and women, and the interpersonal nature of decision making are all part of a disciplinary matrix that affects the career choices of Pakistani women. The arrangement of the education system that forces students to decide their future career so early is not coincidental. It exists and continues to exist unchallenged because it allows continued dependence of students on their families and significant others. The instances of negotiation that I mentioned above are so few

because the possibility of resistance is infrequent in actual practice. Even here, the negotiation was successful because it complied with the broader social discourse of an “honorable” profession. Even when these participants partially defied their parents’ wishes, they chose a profession that was “acceptable” for women. It would have been an altogether different story if one of them had demanded to be a fashion model (a profession that is considered unacceptable for women in Pakistan), for example.

In discourses of gender development, women’s participation in higher education and labor force are often considered synonymous with the empowerment. Though the increase in the number of educated women with professional degrees may seem like a step towards the empowerment of Pakistani women, I am hesitant to call it an unqualified success for women and their social position in Pakistan yet. There are multiple reasons for this reluctance, some of which are familiar to scholars interested in the experiences of working women around the world (like the combination of domestic and job related labor resulting in working women having to take on an increased workload as compared to their men counterparts, which I discuss in this dissertation). More importantly, as I discussed in this chapter, the choice to go into medicine as a profession and being highly educated cannot be interpreted as empowering, as it is often another ethico-disciplinary decision made for Pakistani women by their significant others. Women are submitting to social and family pressures, often at a very young age when they are relatively powerless.

How does one explain the increasing number of women in the workforce in a patriarchal society like Pakistan, then? Women increasingly find themselves in need of a career not because it challenges the gendered division of labor in a patriarchal society but because of the increased encroachment of capitalist economic (increasing social inequity)



and social (increasing nuclear families) changes in Pakistani society. Due to the global economic changes, and resulting pressure on the economy of Pakistan, a “family wage” is no longer a possibility for many households. As men find themselves in increasingly underpaying jobs, women are forced to contribute to family income to maintain the family’s standard of living. Similarly, in the traditional multigenerational family structure, multiple families pooled their economic resources. This gave an economic cushion to the younger generation as they could rely on their parent’s financial resources, particularly early in their career. In a nuclear family structure, this is no longer possible. Even though it gives women (and couples) more autonomy over their financial resources, it also increases the need for women to participate in paid work, while also shouldering full domestic responsibility.

Medicine as a career is simply a path of least resistance, as it caters to socioeconomic changes demanded by the capitalistic order while conforming to the normative gender order. Still, as the exchanges above show, even the most rigid social orders have built in degeneracies, and a potential for instability and change. Education, especially medical education, is an arduous socialization process in itself. It produces capacities for resisting the normative order as an unintended consequence, as I discuss later in dissertation. Furthermore, multiple social actors often have different stakes in the education and careers of Pakistani women doctors. As I discuss in the next chapter, “being a doctor” holds different meaning and value for women themselves, their parents, their families-by-marriage, and society at large. This difference opens up potential for further negotiations.

## CHAPTER 4

### THE DOCTOR BRIDES: LINKING MEDICAL EDUCATION AND MARRIAGE MARKET IN PAKISTAN

“Parents like to make their daughters doctors because then they get good matches for marriage,” said Professor Zahid when I asked why medicine is a preferred profession for women in Pakistan. He has been teaching medicine for more than 30 years and has been the principal of a number of medical institutions, including a women’s only medical college. The connection of medical education to the marriage market may be unexpected, but in Pakistan, where some form of arranged marriage is a norm, it is hardly surprising. Professor Zahid went on to explain further, “Parents in Pakistan really have two responsibilities in their life, to get their son a good job, and to marry their daughter in a good family. As a doctor, women are likely to receive better marriage proposals, and that’s why parents like to send their daughters to medical college.” Dr. Shaheena, a professor of physiology concurs, “People come to me, and ask me to find doctor brides for them from my students.” Dr. Afzal, principal of a private medical college, explains just how strong this connection can be, “Fees in private medical colleges can range from eighty to more than a hundred thousand rupees. Not a lot of people can afford it. But fathers sell their properties, mothers sell their jewelry just to pay the fees, so their daughters can get a good match after becoming doctors.”

The value of medical education in marriage market has been used in social media as well to explain the women students’ surge in medical colleges. Dawn, Pakistan’s most widely read English newspaper, in a 2013 article titled “Doctor Brides” portrayed medical education and women doctors as the latest status symbol. Women, it was said,

became doctors only because it gave them an edge in marriage market, to be “doctor brides”:

Today, the doctor bride signifies status, not simply the cache of brains in addition to beauty, but rather of the incredible largesse of having the option to work, to make lots of money, and then to forego it all in the path of devoted wifedom and motherhood. In this misogynistic equation, a man who can boss a woman around is quite manly, but a man who bosses a doctor around is the manliest (Zakaria 2013).

Several blogs and articles spoke of parents who invested in their daughters’ medical education merely to give them an edge in the marriage market. Some went on to link this phenomenon to women’s decisions to opt out of a medical career: women students chose medical educations only to fulfill their parents’ wishes, and they lacked the impetus and perseverance necessary to survive in a demanding profession like medicine. It was taken for granted that once that aim was achieved, the profession or practice of medicine held no further value for them and they readily left their profession for their homes and their families.

Blogs and news articles covering women doctors generated intense discussion, even among policy makers, about whether a country like Pakistan with limited resources and in desperate need of health professionals should continue to invest in what was termed as substitute for dowry (Abid 2014; Wiquar 2014; Junaidi 2014). Multiple suggestions were offered to retain women doctors in the work force. Instead of a quota, some suggested mandatory service of two years after graduation. Some proposed imposing monetary fines on those doctors who left their careers. Others, decrying the lack of motivation in women and their haste to forgo their career for the love of their families, suggested extensive screening of potential candidates prior to admission to

ensure their motivation to work (Abid 2014; Junaidi 2014; BBC News 2015). Absent conspicuously from these narratives, however, are women doctors themselves, or any discussion of their motivations. This begs the question, how and why does medical education factor in the marriage market of Pakistan? Why are women doctors positioned as ideal marriage material?

This desirability of women doctors as brides and as prospective daughters-in-law, and the connection of a medical pedagogy and career with the social discourses of marriage and match making reveals a lot about how the society evaluates and perceives Pakistani women doctors' education and career. An inquiry into this topic not only produces a detailed account of marriage patterns in Pakistan, but also provides insight into how educated, professional women navigate these social discourses. The topic of arranged marriages in Muslim and South Asian societies also generates intense debates about women's rights, citizenship, human choices and individuality (Abu-Lughod 1990; 1998; Ahmed 1992; Jamal 2006; Yefet 2009; Penn 2011; Critelli 2012). By extending this line of inquiry to Pakistan, in this chapter, I first provide a detailed account of marital matchmaking in Pakistan. I then discuss the discourses of status and prestige associated with professional credentials in medicine, and the subjectivities produced by medical pedagogy that constitute women as the desired "doctor *bahu*" in the marriage market for their future families by marriage. I also focus on the gendered subjectivities produced through rituals of matchmaking and gendered relations of deference. Finally, I analyze women doctors' narratives to understand the complex ambivalences and contradictions in their response to arranged marriages and rituals of match making.

## **Trading in Cultural Capital: Marriage Market in Pakistan**

Before I begin, a brief note about marriage customs in Pakistan is in order. In Pakistan, like many neighboring countries in South Asia, marriage is almost universal (Dube 1997). Although many different types of marriage are practiced in South Asia and Pakistan (Carter 1973; Ahearn 1994; 2001), with different levels of social acceptance, the most socially desirable, culturally ideal and honorable form of marriage is the one that families (usually parents) arrange for their children. In addition, even within arranged marriages, there is endless variation in the spectrum of consent and coercion (for a detailed discussion of types of marriages in South Asia, see Carter 1973; Ahearn 1994). Usually families make decisions when their daughters are of marriageable age, or when they are ready to bring a daughter-in-law into the family. The time considered most appropriate for girls to get married in most urban, middle and upper class families is when a girl has either completed her education or is about to, though she can be married earlier. Similarly for a boy, marriage is considered appropriate when he has completed his education and has preferably started a steady job (Sathar and Mason 1993). Again, there are many variations in this arrangement, usually depending upon the social and economic class of the family, their place of residence (urban/rural), the educational aspirations of the girl herself and the availability of a suitable match. Moreover, the age considered appropriate for a person to marry may also depend on when the persons of the same sex in the same age cohort are getting married within the social network of the family (Desai and Andrist 2010). In Pakistan, like many other South Asian countries, the match considered preferable is usually within the same *biradari* (extended system of patrilineal kinship, literally the brother-hood), or within the same caste, usually within

family's immediate kinship network (Carter 1973; Donnan 1985; Dube 1997).<sup>24</sup>

Traditionally, matches were brokered either by the parents of the prospective bride and groom (if they know each other, directly or indirectly) or by the mediators, usually women (*vicholan* in Punjab, literally the go-between) who have extensive social networks and brokered such matches for a small fee (monetary or in kind). However, with increasing urbanization and the resulting weakening of the social and kinship networks of *biradari*, this work has increasingly been taken over by professional match makers, “marriage bureaus” as they are called, though not completely.

It is difficult to define what is considered a suitable match, though there are some traits that are considered more desirable culturally. Apart from caste, the important factors are the economic status of the family, the reputation and the reputation of the girl/boy, their age relative to each other, their levels of education, and their residential location (urban/rural, within Pakistan/outside, in variously classed parts within the city). For girls especially, their complexion, body type, height, weight, the way they dress and their prowess in the kitchen and household skills like cleaning, sewing, embroidery are also valued (Fricke, Syed and Smith 1986; Elias and Malik 2009; Tariq, Hasan and Ajmal 2013).<sup>25</sup> To find out what characteristics are most sought after in marriage proposals I

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<sup>24</sup> Although caste and *biradari* are sometimes used synonymously, in their modern usage caste is reserved for extended patrilineal networks that sometimes stretch across the nation-states. *Biradari* however refers to more localized social networks with the caste between people of same social standing. Thus a Gujjar in India and Pakistan are of same caste, but not necessarily same *biradari*

<sup>25</sup> Though with increasing modernization, such considerations are also becoming important for prospective grooms, and families or girls now reject matches sometimes if the boy has dark complexion or smaller height. It may be seen as a way of girls having a

looked at the matrimonial section of Pakistan's leading Urdu and English newspapers (Jang and Dawn respectively) for five consecutive Sundays (when the most matrimonial advertisements are placed). Caste is the most common trait mentioned in the matrimonial ads (regardless of gender), followed by the age. For women, 89 % of the advertisements mentioned a physical characteristic (fair color was most common, followed by tall stature), and 85% mentioned educational and professional qualification. For men, job and professional qualification was most commonly mentioned (in 90% of the ads). Similarly, virginity and romantic purity (an awkward term, which I use to highlight the social insistence on maintaining the façade, however fictive it might be, that a spouse has not romantically loved [*mohabbat ya ishq nahi kiya*] anyone before marriage) are considered very important for girls and are much less of consideration in case of boys (Donnan 1985; Fischer 1991; Dube 1997). The negotiations for a prospective match (or *rishta Bhaijna*, literally sending a proposal) are almost always initiated by the boy's family. It is generally considered dishonorable if a girl's family initiates the marriage proposal, as it suggests their hurry to marry their daughter off, implying she is damaged goods in the marriage market.

Social scientists often use the metaphor of the market to understand marriage and its various associated customs (Goldman, Westoff and Hammerslough 1984; Grossbard-Shechtman 1993; Chiappori, Fortin and Lacroix 2002; Musick, Brand and Davis 2012). Marriage is often literally a market in the case in Pakistan. I asked Saima, who has run a

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say in their marriage, levelling the playing field somewhat, but I am hesitant to call it progress.

successful marriage bureau in Lahore for past 30 years, how marriage proposals are finalized. She told me that parents who want to marry their sons or daughters register with marriage bureaus for a fee. They also provide requisite information about their families, for example, where they live, their caste and *biradari* details, their income, number of siblings, the education of their son/daughter and occasionally a picture as well. They also inform the marriage bureau of their “demands”, i.e. what characteristics they are looking for in prospective brides and grooms. Saima further explained, “We match people according to their *demands*, and send the *catalogue* to the parents. Parents can then decide which family they want to visit. Sometimes the two parties get along well and match is finalized. Occasionally we get a party that is too picky, they keep rejecting proposals because their *demands* are too specific. Then it takes a long time.”

The words like “demands,” “party,” and “catalogue” used in match making betray its underlying business-like nature. During my fieldwork, I had the opportunity to observe and participate in multiple rituals of *rishta* and matchmaking, both from the side of a prospective bride and a prospective groom.<sup>26</sup> The minutiae of these rituals, as I note below, betray the underlying ideology of gendered hierarchies, and marriage as a market, which are asserted through these rituals.

When the family of a prospective groom visits the family of a girl, a ritual that is called *lurki daikhna* or *bur dikhawa* (seeing the girl or seeing the match), her parents are

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<sup>26</sup> It is pertinent here to briefly discuss here my role in this situation. Mostly, I was merely a silent observer, usually introduced as a friend of the family. However, during my field work, many members of my own family were involved in match making. In these situations I played a more active role, usually as a member of the family (and used the opportunity to collect more data).



required to show deference to them and be hospitable. Depending upon the prior relationship between the two families, lavish snacks and tea or a feast is prepared. After some time (during which parents make small talk) the girl is brought in (usually on the pretext of serving something) to be inspected. Usually only the parents and other family members of both sides are present, but now increasingly grooms-to-be accompany their parents as well. Future mothers-in-law or other women family members may ask questions regarding the girl's cooking skills or household responsibilities. Her physical characteristics like skin color, height and weight are also judged and commented upon. I vividly remember an occasion where the matriarch of the visiting family asked the prospective bride to sit close to her, and then took spectacles out of her bag to examine her closely. On another occasion, women of the visiting family demanded that their men relatives also need to inspect the bride. The bride's mother intervened, saying that her daughter is not *bhair bakri* (cattle). Sometimes, the prospective in-laws inspect the bride's house (especially kitchen or bathroom) to judge the cleanliness and taste in decoration which in turn is reflective of family's social status. After this thorough inspection, it is still not guaranteed that a formal *rishta* will be sent. Kayla, one of the participants and a woman doctor, for example, reported being seen and judged by almost fifty families before her match was finalized, even though she was a doctor and thus had an edge in marriage market. Girls who are deemed less desirable in this market (darker skins, shorter heights, slightly built or overweight, not doctors) face rejection upon rejection. It is not difficult to imagine the profoundly gendered subjectivity this ritual produces by reducing women to a set of traits, an object for the masculine gaze and desire and a commodity in the market of social capital. Faiza, a 36 year old doctor that I

interviewed, has been receiving proposals for her daughter for past five years. She told me:

People came for proposal, looked at my daughter and never came back. They told me that they were looking for fairer girl, or that my daughter was darker than their son and she just would not look good with him (*sajay gi nahi*). She did not make her skin color. I did not make her skin color. We started thinking about the skin bleaching treatments that are available in the market. But I am a doctor, I cannot let her use that stuff, it has so many side effects. My daughter went into clinical depression. Now, if someone calls us with a proposal, I tell them upfront that my daughter is not fair. If they are looking for someone fair and pretty (*hoor pari*) they should not come to our home.

In this market, every trait of the products on sale (i.e., prospective bride and groom) are classified based on their perceived social, cultural and symbolic capital and that of their families. Symbols of upper class status are valued, such as a big house in affluent suburbs, a bureaucrat or professional father, an American or British accent, and tall stature and fair skin in contrast to indicators of low class status such as a small house in the inner city, a cleric, a farmer or a working class father and darker complexions. Each party evaluates the other mercilessly on these traits. Since this transaction of marriage binds the two families in question in complicated, lifelong relationships of obligations and responsibilities, marriage becomes “the business of the whole group, and not of the agents directly concerned. Through the introduction of new members into a family, a clan, or a club, the whole definition of the group, i.e., its fines, its boundaries, and its identity, is put at stake, exposed to redefinition, alteration, adulteration.” (Bourdieu 1986, 87)

In South Asia generally, and Pakistan specially, status and prestige plays an important role in marriages because people measure their own stature in the community

not only by their own personal accomplishments but also through the cultural capital they have acquired through their social network (Mines 1988; 1994). Hence, every marriage transaction is a carefully orchestrated maneuver, not only maintaining the already existing social, cultural, symbolic and economic capital a family has, but maximizing the accumulation of capital through the new kinship connections made through marriage. Conspicuous consumption through spectacular marriage feasts and huge dowries as a mark of status have thus become a norm, and every family tries to outdo the others in the same social circle in asserting their superior social standing (Bloch, Rao and Desai 2003). These status displays have become so endemic that the government of Punjab had to legally limit the number of dishes offered at marriage feasts and prohibit the display of dowry and excessive lighting and fireworks (Government of Punjab 2015).

Moreover, the word *rishta* (marriage proposal) also signifies the use of marriage for building social capital since *rishta* not only denotes a proposal or a match but also a connection or affinity, so kin are called *rishtadar*, possessors of a connection (Shaw and Charsley 2006). Marriage is also one of the easiest routes for social mobility: marrying a boy to a girl from a family of greater social and economic capital raises the status of the groom and his family and vice versa (Bloch, Rao and Desai 2004). So hypergamy – the practice of marrying in a family of higher socio-economic class – is considered ideal (Shah 2012), but if that is not possible, an attempt is made to at least achieve parity in cultural capital (referred to as being *hum palla* literally the same weight). Qari *sahib*, a professional matchmaker with 15 years of experience in matchmaking, explained the importance of parity:

If a girl comes from a four thousand square feet house, her parents want a match from someone who lives in an eight thousand square feet house. If someone lives in an affluent part of the city, they want a match from the same neighborhood. If someone's son has a good education and job, they want to cash in on it. It is not marriage; it is all business.

### **Marriage Demand: Medical Education as Symbolic and Economic Capital**

Bourdieu (1986) in his discussion of cultural capital classifies its three types as embodied (dispositions of body and mind), objectified (material possessions) and institutionalized capital (institutionally conferred guarantees of certain qualities). Education (or more accurately, evidence of education in the form of certain institutionally recognized credentials) counts towards all of these forms of capital (Topel 2005; Diprete and Buchmann 2006; Becker 2009). A professional degree from a good institution indicates that the family in question is financially secure enough to afford the education (objectified capital). A certain type of profession guarantees a specific kind of acculturation (embodied capital) and a cache of social capital accumulated in the form of contacts and relationships built during the education (Bourdieu 1986). So a graduate from Aitchison, Hasan Abdal or Lahore Grammar School (prestigious private academic institutions) is considered to have a different kind of class than someone who graduated from a public college in a small town, which is still different from someone who graduated from Choefaat or Lahore American School (really selective private schools accessible only to the upper class) and/or spent a semester abroad. An inductee of the Central Superior Services of Pakistan (Pakistan's elite administrative cadre) is assumed to have different cultural capital than an engineer who works in a private company. While later may have more earning potential, the former's social connections and power conferred by his/her official position may make them much more worth investing.

Medicine as a profession has always enjoyed a high degree of prestige across the world (Hodge, Siegel and Rossi 1964; Shortell 1974), and Pakistan is no different in this regard. In a profession like medicine “the accumulation of economic capital merges with the accumulation of symbolic capital, that is, with the acquisition of a reputation for competence and an image of respectability and honourability.” (Bourdieu 1984, 291). A woman doctor I interviewed who, while explaining the prestige granted to doctors, shared an interesting story. Her younger brother once had a flat tire on the road and did not know how to change the tire. Although he waved to several passersby, nobody stopped to help. Then he noticed her sister’s white medical coat in the car. He wore it, and in minutes, people from nearby shops gathered to help the doctor *sahib* (a polite word for a man).

Women doctors know of this prestige and status and use it to their advantage. Students of a medical college told me that they wear their white coat while commuting on public transport to avoid harassment. Similarly, they also sometimes wear white coats while shopping, because shopkeepers offer them bigger discounts as doctors. Statements from my participants similarly provide interesting insights to the symbolic value of the medical profession:

A doctor is always honored. Nobody will be rude to a doctor; they will always refer to a doctor as doctor *sahib* with respect. (Naeem, a doctor’s father)

I think now people are more educated now and they think it will be a show of class that the bride is a doctor. Even though education has been modernized now, there are other fields, but people still think that a doctor is a doctor and it’s the best. And that’s the secret behind so many private medical colleges, people have a lot of money and they are willing to buy the education. (Hira, mother of two women doctors)

It is precisely because of this prestige and status that doctors become a hot commodity in the marriage market. As I mentioned above, parity (as a minimum) is considered ideal in Pakistani marriages (Shaw 2006), so often doctor brides were sought by people who were looking for a spouse for their educated son. I must mention here that such marriage matches are not always calculated schemes completely devoid of emotion (though sometimes they are). As Shaw and Charsley (2006) mentioned in a detailed analysis of transnational marriages among British Pakistanis, parity is considered important, almost a religious duty, because in the absence of any prior courtship, families count on homophily (i.e. sameness) to ensure future happiness of the married couple. As Amin, a professional matchmaker, explained:

Some people look for doctor brides if their sons are also doctors. They think that if they have same background, they will be more compatible. Or if such a need arises, they can both work together to make more money. If someone wants a woman doctor's match but their son is not well-educated, we tell them that this won't work. He must at least have a professional degree or a Masters. Sometimes, people looking for doctor brides are business families who are less educated but rich, and they just want to say to show off their status 'we have brought home a respectable doctor.'

It is interesting to note that while families-in-law prefer doctors as daughters-in-law, the husbands (and prospective grooms) often have a variable attitude towards having a doctor wife. Husbands' primary interest is not in the medical career of their wife, or her education. Rather it is that their wife keeps her end of bargain in the division of labor to which they are accustomed and either becomes a housewife, or even if she works in a paid job, do the housework. Indeed, women doctors' career and paid work, however valued, is always considered less important than and secondary to their domestic work. One man doctor, for example, told me that he specifically requested his mother that he

did not want to marry a doctor, because he wanted someone who would not be interested in having a career and who would want to stay at home. He told his mother that even a girl with only basic education would be fine, but the mother wanted someone well educated to match her son's educational status. They eventually compromised on a girl with an MBA (who does not work in a paid job). A group of men doctors, to whom I put this question during an informal conversation, echoed this sentiment. "I don't care if she works or not. That is entirely her own choice. But I want my wife to take care of the home", was the general consensus. One man doctor went on to say that even though his family wanted a doctor as their daughter-in-law, he was ambivalent about the idea, because marital responsibilities would likely force his wife to give up her career: "I am a doctor myself, I know how hard someone has to work to become a doctor. It would be really unfair to a doctor if she has to forgo her career after marriage."

Nonetheless, the education of women is often valued primarily as a failsafe, where a woman has the option to work (in a culturally acceptable and honorable profession, as I explained in the last chapter) if her husband cannot provide for the family, or cannot maintain the desired standard of living. Given the state of Pakistan's economy, it is becoming increasingly difficult to manage a household with one spouse's wage. Amjad (a doctor himself, and married to a doctor), for example, specifically asked his mother to find a doctor wife, because being an eldest son, he had to shoulder the financial responsibility for his whole family including his unmarried sisters and parents. He knew he would not be able to do that only on his own salary. Thus, economic considerations are becoming increasingly important for prospective marriage matches to such an extent that sometimes people seek a doctor bride because she can generate

income. Samina, a doctor, similarly points to the importance of a possible increase in income as a factor in the desirability of women doctors as daughters-in-law:

It is because of two reasons. Because husbands think that it will be another earning hand. If he is a doctor, he thinks that when I will open a clinic and she will work there, and earn some money. And because the family thinks it is a mark of status. They feel proud to announce that their daughter-in-law is a doctor.

Similarly in an informal conversation, Javed, another professional match maker, pointed out something completely surprising. He suggested that people don't just ask for a doctor bride's match; they want specifically those women doctors who have specialized in gynecology. When I incredulously asked why, he simply responded, "Because they are currency printing machines."<sup>27</sup>

### **Discourses of production: Production of Ideal Pakistani Woman through Medical Education**

Given the symbolic value of educational credentials for cultural and economic capital, their importance in marriage games is hardly surprising (Rose 2004; Chiappori, Lyigun and Weiss 2009). Though this partially answers why education would be important for a good match, the link between medical education (or the prefix of Dr. with one's name, as my participants often put it) and a prospect of a good marriage still needs further unpacking. When I asked my participants how being a woman doctor factored in

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<sup>27</sup> There is no statistical data available regarding doctors' earnings in Pakistan, but this cultural notion that "gynecologists make a lot of money" is quite prevalent among doctors and society in general. It is perhaps because of the assumption that women patients visit only women gynecologists.



marriages, their responses highlighted some interesting dimensions of the cultural valuation of medical pedagogy and profession, especially for women.

For prospective grooms, education combined with a well-paid job indicates financial security for the future family. For prospective brides, education, especially the right kind of education, signifies much more. Apart from being a mark of status, educational credentials imply that their possessor has a certain subjectivity, acculturation and mode of being (Bourdieu 1984). In Pakistan, being an educated woman also signifies having an embodied class based morality, in which women are expected to cultivate middle class values of hospitality, politeness, domesticity and refinement (Khurshid 2012). They are also expected to have the self-discipline to know how their actions could harm them and their families (Khurshid 2015). However, the education has to be “just right”, because families balance the ascribed symbolic status conferred upon women by education with the possibility of rebellion by their educated daughters and daughters-in-law, or the fear that they would be too educated to be married. When I asked Ayesha, mother of a woman doctor, about the relationship of medical education and matchmaking, she told me that she thought of it as a great improvement: “My own mother did not let me complete the finals for masters in biochemistry. She told me that if I got a masters’ degree, I would be considered an old maid and I won’t get a good match.”<sup>28</sup>

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<sup>28</sup> This comment is also an example of changing marriage trends in Pakistani society. Historically women in Pakistan were married relatively young. Ideal time of marriage was 20 to 22 years of age, when a women has just completed her bachelors as this quote indicates, or earlier if she was not getting educated. Women who had completed masters (and hence were older in age) were less marriageable. Now, ideal age of marriage has shifted and Pakistani women (especially those who are getting professional education)

In the marriage market of Pakistan, even the skills and techniques that women doctors acquired as part of their professional training serve to reassert their place as gendered subjects. Their profession is seen as an extension of their caring and nurturing roles which makes them more capable wives and mothers. Naseem, whose two sons are married to women doctors, explained her choice of daughters-in-law in precisely these terms, “Educated women take better care of their children. A doctor mother can benefit her children so much, not just by taking care of their health, but also by transferring their knowledge to their kids. No school or academy can teach like a mother.”

This interesting perspective highlights the complicated (and seemingly contradictory) relationship of education and empowerment for women in Pakistan. While the relationship of education and marriage remains largely unchallenged, professional education for women (like medicine) has not only become socially acceptable but also a highly desired trait. Kokab, a doctor herself and mother of two doctors-in-making explained further:

I think people prefer doctor women as a spouse because medicine is respectable. First, because look, these students go out in the morning and they are back by noon. Even when they are at home they are just studying. Secondly, because most of them have a strong character (*bakirdar*), i.e. are romantically pure. They are so tied up in studies they don't have time to look around and be interested in boys. In comparison there are girls in my family studying other thing, and they have these late night study sessions with boys, so I think medicine is much more respectable in comparison.

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are getting married later in their life, a trend paralleled worldwide. However there is still an expiration date on the marriageability of women in Pakistan. Women who have a PhD or have completed specialization for example are considered less marriageable.

As I discussed in the previous chapter, an important dimension of medicine as an honorable/respectable profession is that it complies with the many gendered social norms associated with women. This response sheds some additional light on it. Especially interesting is the cultural connection between medical education and romantic purity. A doctor is desirable because the difficult and time consuming medical education ensures that she has had little time to socialize with opposite gender. This connection is not superfluous either. Many medical institutions themselves make sure that their students have minimal interaction with students of opposite gender. Rehana, mother-in-law of a woman doctor, for example explained, “Medical Colleges have better environment (*acha mahool*) than other educational institutions. Women medical students just keep their head down, keep to themselves and focus on studies. But in private universities, you see boys and girls sitting together, going on dates. That’s also why parents like to send their daughters to medical colleges.”

There are women only medical colleges established to make it socially acceptable for Pakistani women to access medical education and to introduce gender segregation in education (but interestingly no women only engineering universities). Even in co-educational medical colleges, gender boundaries between men and women students remain very much intact. In all the class rooms that I visited, men and women students sat separately with a respectable distance between them (Figure 3). This arrangement ensured that students were segregated by gender even when they are in same class room or lecture theater. A participant told that on her first day of medical college, after administering the Hippocratic oath, her professor told the whole class that boys and girls should not talk to each other, “You need lecture notes, help with understanding

something, ask someone of your own gender, there are plenty of them, someone will help you, do not go talking to others.” Another young medical student mentioned that her medical college is “especially conservative. If someone saw a girl and a boy talking to each other, it is an immediate scandal.” Other participants cited policing of gender norms by asking women students to cover their heads (i.e. wear a headscarf), or issuing vague threats of giving bad grades should a boy and girl student be seen together.



Figure 3. Together yet Apart: Women and Men Student Share a Lecture Theater

It is important to mention here that participants themselves acknowledged that these threats were never actually acted upon (and apart from the oral part of examination, annual medical examinations are double blinded) but the fear thus generated was sufficient to ensure that students for the most part maintained the gendered borders of

their institutions. Faiza, a woman doctor, similarly noted the desirability of a certain kind of subjectivity produced through medical education for marriage:

When a girl becomes doctor she gets better *groomed* as compared to other professions because this is *an environment of responsibility*. Everyone that gets here (in a medical college) is *intellectually better* than the rest of society, and people also think that doctor girls have a better *character* because they have less chance to... (pause implying relationships with boys) because they have so little time, so people think that they are more *honest* (that is, romantically pure). They have a different perspective on life, they are so much more mature.

When I asked Raheela, a doctor herself and the mother of a woman medical student who was recently engaged to be married, about the desirability of a doctor daughter-in-law, she took a more literal approach:

I think educated people, doctors are much more refined. We [pointing to include herself and I] don't exceed our limits. We don't wear strange dresses. I have met my daughter's class, half of it wears a headscarf, but in comparison if you see her other school friends who went to private universities, you would be surprised to see the kind of dresses they are wearing now, I can't believe they used to study with my daughter once. So this profession polishes you, your dressing, the way you talk and behave. You learn to manage everything, meet new people.

This kind of comportment, termed as “demure modern” (Marrow 2013; Lukose 2009, 77, 80), is a careful balance struck between more Western style and traditional norms of dressing. Doctors during their education and subsequent training develop a sense of dressing according to a certain norm (though it is not primarily to make them better “marriage material”). Fouzia, a medical resident, explained that when her clinical rotations started (in third year of medical college) her professor explained the importance of dressing up to their class. He told them that everyone should be smartly dressed, no jeans or casual dresses for boys, ironed *shalwar qameez* (traditional loose shirt and trousers) or dress trousers were a requirement. Girls should wear simple full sleeved

*shalwar qameez* (traditional loose shirt and trousers), no flashing ornate jewelry, and no Western dresses. “A doctor should look like a doctor”, he explained. Your patients won’t listen to you if you look like a young, careless or an *unparh* uneducated person. This enforcement of sartorial norms and codes of conduct serves a dual purpose. “Looking like a doctor” serves as a visible marker of identity, which creates a hierarchy in the doctor-patient relationship, producing an aura of authority, respect and class around the figure of doctor. It also serves to equate certain kind of norms, dispositions and modes of being (modern dressing, polite and authoritative bearing in case of women doctors) with what is desirable, prestigious and authoritative. Thus “being a doctor” is not just a set of educational credentials and skills and technologies of healing, it also includes the performance of a certain recognizable and desirable embodied subjectivity and disposition<sup>29</sup>.

The importance of pedagogy for producing certain subjectivities and for reproduction of the social order cannot be overestimated (Nash 2003; Besley and Peters 2007). Althusser (2006) pointed out the importance of education in maintaining the social

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<sup>29</sup> See Chatterjee 1989 for a detailed discussion of how education in colonial south Asia is geared to produce the “new Indian woman” who is modern, but not essentially Westernized. This new ideal of femininity is chaste, literate, and adept in household skills, and when she participates in public sphere, her femininity is clearly marked in her religiosity, her dress and her conduct. His discussion of modern Bengali dress that evolved to convey “national identity, social emancipation and cultural refinement – differences that is to say, with the *memsahib*, with women of earlier generation and with the women of the lower classes” (629) is particularly insightful. Evolution of modern Pakistani feminine dress through its various phases, from traditional baggy *shalwar qameez*, to its more form fitting variants to the modern dress of today which pairs traditional styles of *qameez* with jeans or pants can be seen as constant evolution of a modern (but not entirely Western) femininity in Pakistan.

order, as students not only learn techniques and rules of knowledge, but also rules of (socially defined) good and productive behavior, that is, submission to the rules of established social order. The pedagogical apparatuses thus ensure the “subjection to the ruling ideology.” While this may be considered truer for early education (McLeod 2000), medical colleges in Pakistan also perform the same function. They form part of the disciplinary matrix which controls the mobility, sexuality and desires of Pakistani women, which make them desirable brides. The official and unofficial discourses of pedagogy in these institutions produce the embodied sexed, gendered and classed subjects with a certain habitus. Subjects thus constituted learn to police their behaviors to remain within the expected norms of conduct in the given social order (Ameeriar 2015). Through the pedagogy of medicine in Pakistan, women students diligently cultivate a “haute bourgeois” habitus: a restrained, demure yet modern femininity, a refined, caring and cultivated disposition and a capitalist work ethic. They become the “ideal modern Pakistani women”: modern and highly educated, yet chaste and domesticated. It is this particular embodiment that makes women doctors desirable as a possible marriage match.

### **Discourses of the Supply Chain: Education as a Bargaining Chip in Marriage Game**

This specific “sweet spot” of gendered subjectivity with the potential of gains in cultural and economic capital that makes women doctors desirable as a prospective spouse also explains why so many families choose medicine as an education and career pathway for their daughters. In Pakistani society, timely marriage of a daughter is one of the primary responsibilities in a parent’s life, and an unmarried daughter is considered a great dishonor for the family. In this context, the increased demand of doctor brides makes obvious sense. It creates a feedback cycle that explains (in part) the surge of

women in medical colleges. Parents of women doctors who play a significant role in the choice of their daughters' education and careers (as I discuss in previous chapter) are not just responding to the demand of doctor brides, they are also trying to ensure that their daughters achieve "a good life" (Appadurai 2004), which for a woman in Pakistan always includes a husband and children. By educating their daughters in what society deemed desirable, they are merely trying to safeguard their daughters' future happiness. Though this may seem to confirm the allegations by Pakistani media and policy makers, who claim that the parents of women doctors educated them merely to make them desirable in marriage—an "intellectual dowry – it is necessary to understand it from the perspective of a women's parents in Pakistan. The rituals of matchmaking that I discuss above show how women are objectified in the marriage market and the ordeal that women's parents and women themselves go through in the process of arranging a marriage.

Especially after the marriage, patrilocality and husband's absolute control on the right to dissolve the marriage without any liability (financial or otherwise) puts women in an extremely precarious bargaining position (Sen 1987). This is further exacerbated by the social stigma attached with divorce and the impossibility of a woman living alone without the protection of a man (Khan and Reza 1998). Education, especially professional education like medicine, gives women a little better footing. If they decide to leave a marriage, at least they don't have to rely on the financial help of their fathers and brothers to provide for them and their children (assistance that is not always granted). Thus parents of women doctors, by educating their daughters as doctors, are also provisioning for a better negotiating position after marriage. It does not remove the stigma from divorce, but it acts as an insurance against any such eventuality.



## What do Women Want: Marriage and Education

Although the discussion above explicates the cultural discourses that constitute women doctors as desired matches, it would not be complete without understanding how women doctors themselves respond to these discourses. For one thing, the phrase “arranged marriage” hides a whole spectrum of heterogeneity of experiences between coercion, negotiation and acceptance. As I discussed in the previous chapter (in the context of educational decision making), there is a possibility of resistance and subversion in even the seemingly indomitable systems like that of arranged marriages where behavior of young men and women is closely monitored by the families. On one extreme is Shaheena, a 34 year old doctor. She was preparing for her final examination in medicine when her parents informed her that they had arranged her marriage and she was getting married in two days. She had never even seen her husband-to-be (and read his name for the first time when she was signing the marriage contract). Her only response to her parents was, “You could have told me after the exam. Now I will not be able to concentrate.” When I asked Shaheena how she felt about her marriage, she said. “When I joined a co-educational medical college, people in my family came and warned my father not to send his daughter to study with men. She will besmirch your name, they said. But he said, ‘I trust my daughter and I trust my upbringing (*tarbeat*).’ How could I think of betraying the trust of my father?”

Shaheena’s response should not be read as one of helpless surrender in front of insurmountable odds, rather it is one of tacit acceptance. She accepts the eventuality of an arranged marriage (and trusts her parents that they would choose someone appropriate), but at the same time, this acceptance (and her parents’ trust in her obedience) opens the

doors of higher education for her. Faiza, a surgeon, also had an arranged marriage but she was able to negotiate a match where she could continue her work. She told me that when her parents asked her about various marriage proposals that she was receiving, she told them that she would marry anyone who they selected. Her only stipulation was that the prospective groom and his family agree beforehand that they will not stop her from practicing medicine.

More importantly, women do not accept arranged marriage as an uncomplicated, unquestioned given, even though it is the overwhelming cultural ideal. Even when their families have a strong tradition of arranged marriages, women doctors contested it by attempting to arrange their own marriages. Saba, an anesthetist, and her class fellow fell in love with each other. They decided to let their parents know, who approved of their match, and sent a formal marriage proposal for Saba (an arrangement sometimes referred to as an arranged-love marriage). Sameen, another woman doctor, was not so lucky. She fell in love with someone during her education and her family did not approve. She ended the relationship even though the man and his family offered to arrange a wedding without her family's approval. She told me:

The boy I loved, persuaded his family to ask my parents for my hand in marriage. My parents simply refused because the boy was of a different caste, and because he and I were of almost same age. My parents told me that I should have known that our family does not marry outside the caste, and I was stupid to get involved with an outsider boy. I always knew that he and I could never marry. My parents would not accept him and I would never go against their wishes and marry on my own. But I could not control my heart.

These examples point out two important (and seemingly contradictory) things. On one hand, women doctors know of the possibility of alternatives based on their own

individual choices. Similarly, they are vocal in their dislike of objectifying rituals of arranging matches and seeing the girls, in which they are treated as “*bhair bakrian* (cattle)”. But on the other hand, despite knowing the possibilities of individual choice, and having the means to do so (as their love affairs indicate), none of them directly challenge the discourses of match making and arranged marriage. Even those who, like Faiza, negotiated for more favorable matches, or who, like Sameen or Saba, tried (successfully or unsuccessfully) to marry based on their own choices, ultimately decided to submit to the approval of their families. Indeed, their negotiation for a better match, or a spouse of their choice, was made possible only because their subjective position as respectable, educated women made any choice other than normal and acceptable arranged marriage almost impossible. Sameen (mentioned above), explained it further, “I have three younger sisters, all of them studying. One misstep of mine would cost them their education. If I run away and marry against my family’s wishes or get divorced, how will my sisters ever get married, because it would be dishonoring for my family.” Naheed, another women doctor, whose parents similarly refused to allow her to marry according to her choice explained her decision to go along with the arranged marriage:

I cannot say that I was not hurt. But at the end of the day your choices have consequences for you and your family. If I had insisted on marrying against my parents’ wishes, I could never ask for their help with any problem in my marital life. Because my parents told me that they would marry me where I wished, but then I would be dead to them. They said, do not show us your face after dishonoring us. How could I insist on my choice after that? I loved my parents more than anyone else.

Memoona, a woman doctor who had an arranged marriage similarly explained why she thinks arranged marriages are better than the ones based on your own choice, “I think arranged marriage is better, at least in our society. In Pakistan it is not two

individuals marrying each other. It is two families joining each other. If someone marry on their own choice, they lose their family's support and love.”

These responses highlight the ambivalent subjectivities formed under relations of domination, whereby women tacitly accepted arranged marriages given the social order they had to contend with. Women doctors' response to the desirability of a “doctor bride” and the discourses of marriage and matchmaking rituals is similarly fraught with ambiguities. It is perhaps best exemplified by Sara Zafar Khan, a doctor who did not practice medicine after her marriage. In her post titled “*The Doctor Bride*” (2015), which has been shared more than a thousand times since she posted it on Facebook, she asserted that in becoming a doctor, she did not the place of a man student. She worked hard and gave it everything and if boys wanted to be doctors, they could follow suit. She went on to say:

[Mother-in-law] I didn't study medicine to get married because your son isn't worth it. Guys, stop having delusions of grandeur. [...] If [medical education] really does increase marriage prospects, how is it any different from girls dieting and working out just so they can have the size zero figure. Or girls going out decked in makeup, fancy clothing to make themselves attractive. Why is that OK?

Her statement seems strangely ambivalent. While she challenges the perceptions that devalue her motivation to get medical education, she simultaneously reasserts the hierarchies that position women doctors as desired matches. Indeed, education becomes a buy-in to the marriage market that objectifies and categorizes women on the basis of their traits: Some women make themselves desirable by making themselves physically attractive, others use education to same end. Javaria, a 34 year old doctor, echoed her sentiments:

I did not study medicine because of marriage. At that time, I do not think any student is thinking that far ahead. But I received very good marriage proposals. Now if I honestly think about it, given my family's social status and their financial conditions I would have never gotten married in such a good family if I was not a doctor. So medical education does play a role.

Hina, another woman doctor whom I asked if being a doctor played any role in her marriage, was more direct. She said that almost all of her women class fellows were married in very good families, and hardly any of them had any problem with marriage proposals, and as she put it, "It would not have been possible if they were not doctors."

As Ortner (2006) and Giddens (1979) point out, subjects are not completely unaware of their position in the social order. Even in their seemingly unquestioned acceptance of the world around them, they are aware of the possibility of a reality other than the reality to which they are being subjected, however imaginary or utopic it may be (Lugones 1990). Women doctors are constituted as subjects within the relations of power, and to that extent, their decision to submit to social and parental authority, and their acceptance of arranged marriage is part of their subjectivity which self-governs according to the norm. But because of their education they also have access to alternative discourses of individual choice and women's rights. Because of their profession and education, they also have the means to resist the powers of domination they face like parental authority, strict control of their sexuality, complex structures of honor and deference and gendered ideologies. As their romantic affairs indicate, they can also refuse to participate in match making rituals that objectify them and insist on their own individual choice. Women's audacity to love, in direct defiance of their families and the norms of purity and honor despite knowing that it is most likely doomed to fail, is the act of provocation that

exemplify the negotiations that happen even within the narrow subjective space offered by subjugating power relations.

However, is it at all possible to for women to refuse to participate in the marriage market as a more radical act of defiance? As I noted above, marriage in Pakistan is almost universal, and women who remain unmarried are extremely stigmatized, so the choice to opt out of the marriage market is not straightforward. To put this choice in perspective, sexual relations outside marriage even between consenting adults are illegal in Pakistan, and are considered a punishable offense. However, during my fieldwork, I did encounter women who have remained unmarried well beyond the age by which a Pakistani girl is expected to be married (mean age at marriage in Punjab is 18 years) (Jejeebhoy and Sathar 2001). None of them completely opted out of the marriage market: their families received proposals and they were “seen” by prospective in-laws. Some of them, however, creatively subverted the matchmaking discourses to delay their marriage. Ansa is a 35 year old medical resident in a large private hospital. Her family did not allow her to marry according to her own choice, since the person she liked was outside her caste. She in turn refused to marry anyone that her family chose by cleverly subverting the rituals of matchmaking, as she explained:

The guy I loved sent proposal for me and my family refused. His parents begged my parents to reconsider, they even touched my parents’ feet but my father did not listen. I did not want to dishonor my father and brothers so I just kept quiet. But I told them if I am going to marry any one, it will be my choice or I will die unmarried. Whenever they bring someone to see me, I refuse to meet them, or I act really rude. Nobody comes back after that.

Parents of Shahida, another women doctor, similarly refused to marry her according to her choice. She found a job that was in a city far from her native town, and

started living in a women's hostel. Using her duties as a pretext, she met her family very infrequently, and kept refusing any marriage proposal they suggested. She explained how she finally got married, "One of my senior colleagues proposed me, and asked that he wanted to send his parents to my home. He was a nice person and I said yes. By then I was 33 years old. My family had given up on marrying me. When this proposal came, they happily agreed to my choice."

### **Education and Marriage: An Unholy Alliance**

The real political task in a society such as ours is to criticize the workings of institutions that appear to be both neutral and independent, to criticize and attack them in such a manner that the political violence that has always exercised itself obscurely through them will be unmasked, so that one can fight against them. (Foucault 1971, 41)

Throughout the discussion above, I have deliberately yet cautiously used the metaphor of the market as an organizational principle. However, I have done so cautiously because this metaphor reduces my participants to commodities and objects of exchange. But I have used this metaphor deliberately because I want to highlight the gendered dynamics of these relations of domination which make these norms and rituals possible. Understanding how these relations of subjection are made possible and reproduced over time and as Foucault (1971, 41) suggested, critiquing the political violence exercised through these relations is not possible if the gendered hierarchies assumed in these rituals are not laid bare.

The experiences of women doctors in Pakistan reveal how ostensibly empowering projects of education and work can be appropriated by an already existing gendered order. Their accounts also illustrate how women doctors experienced multiple contesting discourses regarding their work and education and the complexities embedded in their

lived experiences. Freedom in marital choice is an important site where discourses of empowerment and women rights focus, creating a narrative in which women in Muslim societies are portrayed as victims being subjected to indomitable patriarchal discourses (Abu-Lughod 1990; Phillips and Dustin 2004; Jamal 2006; Khurshid 2012; 2015).

Agency and empowerment for Muslim women is often considered equivalent to struggling against the bonds of tradition and family to assert modern, western notions of personal choice and individuality (Abu-Lughod 2002; Kurshid 2012; 2015). In Pakistan, similar dichotomies of tradition and modernity, and human rights and local traditions are employed by human rights' groups to examine a few high profile legal cases of women who married against the wishes of their families and the legal debate about the right to marital choice granted to women in Pakistan's constitution (Jamal 2006; Yefet 2009). Others (Abu-Lughod 1990; 2002; Mahmood 2001) oppose this monolithic narrative of agent-victim subjectivity employed to describe the experiences of Muslim women. They assert the importance of contextualizing the relations of subordination in the lived experiences of women who embody these relations (Mahmood 2001).

As I discussed above, given the local conditions and avenues of action available, women doctors' responses to discourses regarding marital choice range from resilience in the face of overwhelming odds and negotiation to outright refusal. Women doctors' multilayered and varied responses illustrate that the resistance and refusal is often not straight forward. Women could access certain avenues of self-expression and power (education and career for example) only if they strengthened (willingly or unwillingly) other sites of their oppression and domination. While refusing to let their career and work be devalued, and challenging restrictions on their education, they simultaneously



reinforce the gendered hierarchies that exist between them as desired “doctors *bahu*” and other less educated women (Khurshid 2015). They also reassert the subjectivities that position them as bearers of a certain class and status. Even in Sana’s arranged love marriage, the necessity of parental blessing and the necessary performance of rituals of sending a match and seeing the girl not only reassert the discourses of parental authority and familial control of women’s sexuality, it also reproduce the gendered hierarchies between bride and groom, and between their respective families, even as her act of choice positions her against these relations. This asserts the fact that there are no pure acts of resistance and acts of agency and resistance can only be understood in the context of inequities they contest. This is a theme that I will continue to explore as I focus on women doctor’s work in the next section.

## SECTION 2

### BEING A DOCTOR

The persistent responsibility of women for provisioning care of every sort, in and out of the household, means that women both require the visible social infrastructure that neoliberal aims to dismantle through privatization and are the invisible infrastructure sustaining a world of putatively self-investing human capitals.

(Wendy Brown, in *Undoing the Demos*, 2015, 106)

I do not think you should include what I said in your research. You would have wanted to hear that women should work. Right?

A Pakistani Woman on Work

Marriage acts as a watershed point in the life of a Pakistani woman. Her social position changes from a daughter in her parents' household to a wife and daughter-in-law in her mother-in-law's household. She enters her marital home with little social support and it takes her years to establish a relationship with her husband (whom in many cases she has never known before marriage) and to acquire some status as a mother.

In this new social role as a doctor, she has to balance multiple demands on her time and labor. She has to manage her domestic responsibilities with a very demanding profession.

The chapters included in this section explore various aspects of this balancing act between various interconnected areas of living. I begin with an exploration of transit spaces. This is an aspect of work that only recently has caught attention of feminist geographers. In Pakistan, differential access to mobility resources and public spaces due to Pakistan's particular social, cultural and religious history has an important role in women doctors' participation in work. These mobility restrictions affect almost every aspect of women's career and education, beginning from the choice of a particular field, to choice of a particular specialty and to day to day management of work and other responsibilities of life.

In medical workplaces, women face several challenges in acquiring the resources required for professional persistence and success. Pakistan's particular social background, especially the norms of modesty and purdah, the gendered division of labor at home and in public sphere, and public disinvestment from social welfare policies, particularly those that support working women and their families, have a major impact on women's career decisions.

## CHAPTER 5

### DRIVING THE CHANGE: NEGOTIATING THE PUBLIC SPACES IN PAKISTAN

#### **What's the Mobility Got to Do with Work?**

I met Selma on a sunny afternoon on the side of a busy road in Lahore. Her clinic was located in a maze of streets, difficult to understand for a first timer, so she kindly offered to pick me up with her car at a busy intersection. As she deftly maneuvered her way through the chaotic traffic, we started talking about how she had learnt to drive. “I had to learn if I wanted to continue my career as a doctor, and it wasn’t easy for me. Even now I can barely navigate these congested roads,” she told me. I must admit that my question was partly grounded in my own experience: I reached that intersection on a rickshaw, because I, a thirty something doctor-turned-anthropologist, cannot drive myself. Like me and many other doctors that I interviewed during my field work, Selma, a professor of surgery and an expert driver now, learnt to drive much later in life and she did it for the sole purpose of continuing her career as a doctor.

Women have had a complicated relationship with automobiles historically (Sanford 1983; Scharff 1991; McShane 1994). Cars have been portrayed as a ticket to freedom and leisure, a way of breaking free of the traditional gender roles that tied them to the household (Simmons 1983). They are seen as sexualized spaces, dangerous for young women, or as part of the identity of a suburban soccer mom, chauffeuring her kids around the town (Sanger 1995). Stereotypes of woman drivers and their inability to understand directions are still prevalent (Berger 1986; Shinar 1998; Yeung and Von Hippel 2008; Granie and Papfava 2011). Despite decreasing differences in the mobility

patterns of men and women in developed countries, women still work closer to home, are more likely to use public transportation (Wachs 1987; 1988), make more non-work related trips (Wachs 2000), and give up their driving privileges early in their old age (Burkhardt, Berger and McGavock 2000; Hakamies-Blomqvist and Siren 2003), limiting their access and mobility.

Still, for most women, especially in developed countries, knowing how to drive is not something unusual, and learning to drive is a milestone more commonly associated with teenage years. In Pakistan, however, this issue is much more complex: While driving is legal for women, and many women, especially in urban areas, increasingly do so, there are far fewer women drivers on the road than men. Women who do drive often learn it much later in their life. The issue of driving and personal mobility has a particular importance in shaping the everyday life of women in societies like Pakistan, where the mobility of women is closely monitored and often restricted. The ability to drive (and hence the ability to be mobile independently) in this context can be a crucial factor towards empowerment and gender equality, as it allows greater access to better healthcare, education and career opportunities (Khan 1999; Mumtaz and Salway 2005; Hjorthol 2008; Roomi and Parrott 2008). Especially in the context of working women in Pakistan, access to modern transit technologies (including access to roads, vehicles and transportation practices like driving) can significantly affect women's participation in the labor force. However, surprisingly little research has focused on the mobility patterns of working women in Pakistan and how it affects their occupational choices.

Similarly, organization and structuring of space around us is a critical dimension of social and cultural life. Social space reflects the inequities, hegemonies and power relations assumed in a society, and in turn influences the social relationships and identities of the individuals that inhabit this space. Hence, an examination of the embodied experiences of mobility of Pakistani women can provide a nuanced account of how everyday practices of mobility and spatiality can be implicated in the reassertion of rigid gendered structures of privilege and injury, by providing uncomplicated access and spatial freedom to some (those of a certain gender, class and race) at the expense of others. It also provides insight to the social and cultural discourses that produce gendered boundaries and mobilities in Pakistani society and the importance of acquisition of spatial skills and technologies (like driving) for the purpose of contesting the gendered (b)orders at both individual and social levels (Kallius, Monterescu and Rajaram 2016).

Finally, women's differential access to transportation and related technologies plays an important role in limiting women's geographical mobility, and hence their career choices. But as Law (1999) notes, most of the existing literature on women and transport has a behavioral or policy-driven focus. However, surprisingly little research has focused on the social, material and economic implications of changing trends in gender variation of transport skills. Similarly, most of the previous research on mobility of working women has been focused on developed countries and/or Western contexts. Limited research has explored the material-discursive practices related to religion, culture and politics that influence the mobility of working women in developing countries in the non-Western world.

In this chapter, using the narratives of women doctors, my aim is to understand how gendered practices of mobility are implicated in creating and maintaining the gendered relations of power in Pakistani society. I begin by briefly explaining the theoretical and critical perspectives on gendered mobilities. I then discuss the social and cultural discourses related to women's space/place in Pakistani society, as well as the gendered design of urban environments and transit resources in Pakistan. Finally, using the example of driving as a specific practice of mobility, I discuss how women doctors, in order to further their education and career, not only negotiate the patriarchal structures of the society which limit their mobility, but also challenge the gendered construction of public spaces.

### **Theoretical and Critical Perspectives on Gendered Mobilities**

From the symbolic meaning of spaces/places and the clearly gendered messages which they transmit, to straightforward exclusion by violence, spaces and places are not only themselves gendered but, in their being so, they both reflect and affect the ways in which gender is constructed and understood. (Massey 1994, 179)

As the quote above indicates, social and cultural processes that lead to the production of gendered identities also produce a profoundly gendered perception of the space around us. Both men and women, throughout their lives, internalize multiple normalizing discourses around them regarding the spaces in which they belong: where it is natural or normal for them to go or to be, and how much freedom they do have in moving from one place to another or across certain boundaries. Spaces and places thus impart social meaning to bodies, and the spatial placement of variously sexed, classed and gendered bodies confer meaning to the spaces in an ongoing process (McDowell 1999; Massey 1994). Hence, perception of space and mobility, spatial organization and

architecture becomes an important nexus through which society influences, produces and sustains multiple axes and stratifications of social and political orders.

Analysis of access, mobility and immobilization thus exposes the complex political relationship of space, place and power in a society (Spain 1992; Massey 1994; McDowell 1993; McDowell and Sharp 1997). Varying degrees of restriction on spaces in the form of boundaries and mobility across them is an important mode of disciplinary control of bodies in contemporary societies, and defining citizenship in modern states. Institutions like prisons, mental health clinics, quarantines for disease control, and international borders are by their nature defined by the foundational restrictions on the mobility of one group or another (Foucault 1977). Borders and restrictions to mobility are much more than (real or imaginary) lines, they are an effective deployment of the values and morals of a social order (Kallius, Monterescu and Rajaram 2016). Being restricted to or associated with a specific space/place also means being tied to a specific set of identities, and being identified with certain subject positions grants one with a certain set of rights and degree of everyday citizenship.

An important question in this regard is to understand what the consequences of differential patterns of mobility are for men and women. Women's embodied mobility in the form of the minutiae of gaze, gestures and gait is an important component of how gender is done in everyday life (Young 1980, West and Zimmerman) and subverting this embodied mobility, for example in the performance of drag, then becomes a way of "undoing gender" (Butler 2004a). In Pakistan and other Muslim countries, the practice of a particular spatiality and mobility (guided by the percepts of *purdah* and modesty) is



similarly an important part of feminine bodily comportment. Feminist scholars (Cresswell 1993; 1999; 2011; Law 1999; Uteng and Cresswell 2008; Massey 1994) also assert that geographical mobility and accessibility produces the differential power relations between genders by mediating access to resources of knowledge, time, money and technology, and hence is important in determining women's broader social role. Limiting women's place/space to the private sphere of household in modern industrial societies creates the gendered distribution of labor, where women's work is limited to social and biological reproduction, but excluded from the public realm of political discourse and waged work. The dichotomy of public/private is physically writ in designing modern urban cities with a spatial separation of the private space of home and the public area of work. Gendered division of childcare and domestic work, overlaid with the spatial separation of work/home and public/private, combined with the work-centered culture of the workplace, results in gendered space-time constraints for those who are primarily responsible for domestic work, usually women (Kwan 1999; 2000). This directly contributes to gendered occupational segregation since women are often forced to work close to their homes, make less money and have limited mobility across jobs (Pratt and Hanson 1991; Law 1999).

### **Context of Mobility in Pakistan**

Women in Pakistan similarly face numerous cultural and social difficulties in accessing public spaces and in their everyday mobility. Specifically in the case of working women like doctors, difficulties in commuting to work play an important role in their career outcomes. In the discussion that follows, I discuss the social, cultural and

material aspects of mobility of Pakistani women doctors. My analysis is based on the spatial triad proposed by Lefebvre (1991), postulating that mobility is produced dialectically through its perceived, conceived and lived aspects. *Perceived mobility* is what Pakistani women experience as part of their daily lives and what has been produced through the historical social and cultural processes. *Conceived mobility* details the cityscape and material structures involved in mobility, like roads, public transport and personal vehicles etc. Finally, I examine the practice of driving as an example of *lived mobility*, where women doctors negotiate and challenge the limits created by perceived and conceived aspects of mobility.

#### Perceived Mobility: Social and Cultural Construction of Mobility

“I trust you my daughter, I just don’t trust the world”, was the answer I always got from my father whenever I questioned the manifold precautions I had to observe before stepping “outside”, and it exemplifies the dilemma of mobility faced by women and their families. Space for women in Pakistan is always oriented between the two axes of *Andar* (inside) and *Baahir* (outside), where women’s place was firmly located in the private realm of “inside”. The history of this dichotomy can be traced back to nationalist movements in pre-partition India. Between the contradictory pulls of overcoming the trauma of colonialism as well as defining a national identity distinct from their colonial masters, nationalists of pre-partition India reimagined the private sphere of “inside” as the locus of true Indian identity, in contrast to the public sphere of “outside”, the material profane world where colonial culture had subjugated the culture of motherland. Women, as the representation of “private/inside”, were cast as the embodiment and symbols of a

true Indian essence, and as the protectors of traditional values, women became the center of defining a uniquely Indian identity and anti-colonial resistance (Chatterjee 1989).

“Women’s place” thus became central to the process of identity construction and citizenship in pre-partition India (Roy 2014). This process continued after partition and specifically in the case of Pakistan was further intersected by cultural and religious discourses of modesty and *purdah*. Control of women’s sexuality and disciplining their bodies became the main thrust of defining a uniquely Pakistani identity, especially during the process of islamization in the Zia-ul-Haq regime. Laws like the Hudood Ordinance are aimed to portray women as dangerously, sexual beings who need to be limited within certain boundaries (Hudood literally means boundaries). Outwardly, this pre-occupation of nationalist discourses with the bodies of women manifested as specifying modest dress codes and behavior rules for women appearing in public spaces (like newscasters and air hostesses) and banning the sexual mobilities of dance from public television. The state thus assumed the role of a patriarchal protector, binding women to their rightful place/space within *chadur aur chardiwari* (veil and four walls). The feminist movement of Pakistan against these transgressions on their citizenship was articulated in the language of mobility as well: by organizing public protests, debates and sit-ins (Charania 2014), and more recently, by organizing flash mob dances, by organizing women’s marathons and urging women to go to street side *chai* stalls.

It should be noted that the social boundaries of feminine inside/masculine outside do not map literally onto the geographical inside/outside of home. Rather they are culturally co-constitutive referential categories which are always understood in relation to

each other, with no clear boundary between them. The dichotomy of inside/outside is best understood as a “discursive phenomenon that, once established, can be used to characterize, categorize, organize, and contrast virtually any kind of social fact: spaces, institutions, bodies, groups, activities, interactions, relations.” (Gal 2002; 80, 81) Thus, “outside” spaces (public spaces, spaces associated with low social class) and “outsiders” (non-kin people, men outside the immediate family, people of a different social class or race) are portrayed as threatening and dangerous. The result is not an improved access of women to public spaces; rather, the concern for women’s security is articulated in restrictive terms of respectability and territoriality, where “respectable” women do not venture in “the ‘wrong places’ at the ‘wrong times’, wearing the ‘wrong clothes’”. (Arondekar 2012, 28)

Similarly, on a micro social level, the honor of patriarchal masculinity is tied closely to the control of women’s sexuality and mobility. Since childhood, the mobility of women, especially outside the home is closely monitored and often restricted. Girls are socialized at an early age about what places to avoid, when not to go out, and to pay close attention to their appearance or dress when entering “outside” spaces. In contrast, young boys and men are encouraged to play outside and to socialize with friends outside their homes, and their mobility inside the homes and outside is much less restricted. The mobility of women is thus limited to “transparent spaces” where their movement, dress, bodies and gaze can be surveilled and monitored by their families and communities (Mohammad 1999). It should be noted here that while these restrictions on women’s mobility are much more “visible” in countries like Pakistan, they are no less pervasive in

Western countries, where this surveillance takes the form of various shaming and stigmatizing behaviors for women who transgress gender norms.

In Pakistan, these restrictions can pose a serious challenge for accessing basic facilities like health and education (Khan 1999; Mumtaz and Salway 2005; Saleem and Bobak 2005). Girls may prefer to go to an inferior college that is closer to their home, rather than traveling long distances to a better one. Many of my participants, for example, were only allowed to choose a girls' only medical college, since it minimized their interaction with men, especially of their own age. This becomes an even more crucial factor in smaller cities and rural areas, where girls may have to change their major or forego education altogether because there is no school or college for girls near their homes, and their families either won't allow them to travel or can't afford to do so.

Even when they are away from home, the mobility of girls is tightly controlled at residential educational institutions. Residential hostels for girls maintain strict curfews<sup>30</sup>. At Fatima Jinnah Medical College (an all girls' college), for example, students have to sign their names when they leave hostel premises and if they are not back by 9 pm, their parents are notified. Other colleges with women hostels have similar policies with variable restrictions. Families also use their extensive social networks and technology (mobile phones, for example) to extend their social control on the mobility of women. Women are expected to seek permission from their families before they leave their homes

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<sup>30</sup> These are by no means unique to Pakistan. Similar policies exist elsewhere in South Asia (Jagers 2013). In India, women students organized protests against such curfews with limited success.

or place of residence, and inform them of their safe arrival at their destination. Married women have to ask permission of their husbands (and parents-in-law if they are living with them), even when they are visiting their own family.

This distinction of outside/inside is further cemented by the threat of violence (perceived or actual) and the hostile materiality of outside, public spaces. My father's advice of not trusting the world was not off the mark. Almost all of my participants had stories of being harassed on the road, which ranged from staring, catcalling, inappropriate touching, to being threatened by a gun. This is hardly unexpected; even in Western countries where women ostensibly have more access to public areas, more than 65% women report being harassed on the street (Stop Street Harassment 2014). In fact the surprising thing about these stories was how unremarkably they were told, often with a sardonic chuckle. For most women it was part of the "routine", part of the price they paid to walk along the road and they have come to accept it (Figure 4). Padhke, Khan and Ranade (2011) in a study of women's experiences on Mumbai streets similarly noted that while men have unlimited and unquestioned legitimate access to public, urban spaces, the same right is not extended to women. The unfettered right to the city, to the road, and to just *be* in a public space belongs only to the masculine.



Figure 4. A Pakistani Woman Artist's Depiction of Walking on the Road<sup>31</sup>

Even though restrictions on mobility of women are often articulated in terms of love and security, they do not actually translate into the protection of women in public spaces. More importantly, women on the street are viewed as transgressors, who do not belong in the public space. Although there are multiple laws in Pakistan's penal code against "obscene acts against modesty of women", crimes of street harassment are rarely reported by the victims for the fear of tarnishing their reputation (which paradoxically, further restricts their mobility by increasing the threat of scrutiny). Shahida, a 42 year old

<sup>31</sup> Drawn and illustrated by Shehzil Malik, used with permission. The original and accompanying story can be accessed at her tumblr <http://shehzilm.tumblr.com/>

woman doctor, passed a vehicle during routine driving on a road in Lahore. The driver of the vehicle enraged, pulled in front of her car and pointed a gun at her. She did not report it to police, or to her family. When I asked her why, she told me wryly:

I have not stopped shaking inside since then. I couldn't even tell anyone. If I told my husband, he would just say, leave the job, stay at home. Yesterday, I finally gained enough courage to tell my father, pretending it happened to someone else. And he said, 'I am sure that lady also has some fault in it'. (Laughter) I was dumbstruck. If my own father thinks like that, who else will listen to me?

Instead of being validated or supported, victims of street harassment are more likely to be told that harassment was their fault. Similarly, Saira, another woman doctor was walking along a main public road in Lahore during day time, clad in jeans, when a couple of men riding on a motorcycle starting harassing her. Passing close to her, one of them slapped her across her back. A policeman witnessing this incident did not interfere. When she requested him to stop the men, he told her instead, "Wearing clothes like this, what else did you expect?"

As a result of this surveillance, women learn to continuously self-discipline their movement to such an extent that it becomes their "mode of being" (Lefebvre 1991). Jeem, now a confident medical officer in a teaching hospital, mentioned that she had to live in a hostel while attending medical college, since her family resided in an another country. She told me that throughout her medical education, she did not leave the premises of the hostel unaccompanied. Her men relatives who lived in the city sometimes visited her and she had to request them to accompany her so that she could shop for groceries and items of personal need. When I asked why, she explained:



I was afraid, what if something happened or someone from my family saw me, they will say. ‘She came from another city to study and what is she doing now? Loitering outside!’ I never attended any class function, never left the hostel, [I was afraid] that if someone saw me and spread the rumor that she wanders around outside, even though she came to Lahore to study, and told my parents, they might call me back, saying what are you doing wandering around!

Mobility, however, is not just spatial: time is also an important component of mobility. The gendered division of labor and domestic work within families puts extra constraints on women’s time. Working women particularly perceive imbalance between the demands of their work and their household responsibilities – the “time-bind” (Hochschild 1997). Not only does this create stress for working women during their day to day life, (for example figuring out how to pick up a child from school at 1 pm, when their shift ends at 2 pm), it also makes them less free to move, as they rush from one assignment to another and one chore to the next. This is further exacerbated by the lack of care structures in workplaces (like childcare centers, or flexible work time).

In Pakistan, cultural taboos of night time mobility are particularly important, especially for women doctors who often have night and evening duties. Public spaces are perceived as hostile during nighttime, and going out at night, or spending the night outside unaccompanied can be extremely damaging to a women’s reputation and her family’s honor. Women doctors thus tend to choose specialties which do not have night time duties. Many hospitals and medical institutions have unwritten policies that women are not put on night time work rosters. However, as the number of women among the doctors increases, these cultural restrictions create difficulties for health providers and hospital management.

## Conceived Mobility: Design of Transit Spaces

The design of the transport technologies and infrastructure, and the distribution of transit resources also have a significant impact in how women experience the spaces they inhabit and the freedom of movement they have within these spaces. Women are more likely than men to perceive urban environments as threatening and unsafe, severely curtailing their access and mobility. To be in control of their safety, women do a subconscious threat assessment of their surroundings, trying to anticipate the spaces and situations where violence may occur in order to avoid it (Gill 1990). Scholars of urban design and architecture therefore advocate designing urban spaces (conceived mobility) that minimize the threat to women's personal safety by increasing visibility, and minimizing isolated and dimly lit areas so that women feel more in control of their surroundings. Design of public environments therefore influences women's sense of security, and hence their willingness to access and use them (Valentine 1989; 1990; Day 2001; Pain 1991).

Most Pakistani roads, even in the larger cities like Lahore, do not have any foot paths or any pedestrian signals. There is no designated space to walk, *for anyone*. The edge of the road is a battle ground. This space is shared by parked cars, rickshaws and buses, road side stalls, merchandise from shops and intrepid pedestrians weaving their way through the mess. Few roads have street lights, and even they stop working in the rolling black outs resulting from electricity shortfall. Even though the lack of infrastructure affects both men and women, constant fear of harassment makes roads hostile spaces for women and limits their mobility. Walking along the road, women know

instinctively to steer clear of men, to preferably be in a group, to avoid certain areas (poorly lit streets, areas of low socioeconomic status, anywhere after dark), and to blend in, becoming as invisible as possible.

The public transport system is no better. It operates only on specific routes, and these cover only a small portion of the city. More importantly, since public transport is frequently used by men of a lower social class (who are perceived as outsiders and threatening), public transport is not considered a “respectable” way of travel for women. Hence, in many areas, even when public transport is present, women avoid using it. Interestingly, instead of making public transport safer and more acceptable for women, government policy attempts to keep men and women in their respective place/space. A special area is designated in each public transportation vehicle for women, often with a separate entrance and a separating wall. However, this area is much smaller and has fewer seats, perhaps indicative of the assumption on the part of the government that fewer women would need to travel. As a result, women’s enclosures are often overcrowded and women find it difficult to get a seat. Even here, women passengers are not safe from harassment at the hands of their fellow passengers and drivers (International Labor Organization 2012). The waiting areas at bus stops are often derelict and poorly lit, making them threatening for women. Though in many cases there is a separate space for women, because of overcrowding, even these areas are occasionally occupied by men. In some cities, women entrepreneurs have tried to establish women-only transport services (like pink rickshaw in Lahore, or pink vans in Rawalpindi), but since they have yet to gain widespread popularity, it is difficult to say whether they have

any effect on the transportation facilities for women. A recently built rapid bus transit system has better facilities for women, but it only covers a small area of the city.

In the absence of a public transport system, vehicles for hire are an important resource for transportation. Taxis and ride sharing services like Uber cost much more and they are available only in few large urban centers. However, because of the cost, it is not possible to use these services for regular commuting. Furthermore, taxis and cars are perceived as unsafe for women, because of potential threat of harassment and the cultural taboos of being alone in enclosed spaces with men. Rickshaws, small motorized vehicles with hooded canvass cover, on the other hand are a popular choice (Figure 5 and 6). They are relatively cheap, and ubiquitously available for hire along the road. Many women who regularly commute by rickshaw hire one on monthly basis as a personal pick and drop service. Women also perceive them as much safer than taxis, since in case of any threat, it is much easier to get out of a rickshaw (most of which do not have any doors).



Figure 5. Queue of Rickshaws Waiting Outside a Public Hospital



Figure 6. A View of Lahore's Traffic from Inside a Rickshaw

In the given transit infrastructure, owning a personal vehicle and driving it is often the easiest way for women for regular commuting. However, owning a car for most middle and working class families in Pakistan is a luxury. Unlike the US, where more than 90 percent households have at least one vehicle and there are almost 800 cars for every 1000 people (US Bureau of Transport Statistics 2003), Pakistan has only 18 cars per 1000 people. This issue typifies how broader socioeconomic factors create conditions for differential availability of resources for different genders. Since Pakistan does not have a well-developed local car industry, most cars in the country are imported and quite expensive. To illustrate, an average Pakistani makes around \$1, 500 a year (World Bank 2014), and the cheapest car in the market, Suzuki Mehran VX, costs around \$7000.<sup>32</sup> Even though the government has allowed the import of used foreign cars to make automobiles more affordable, and the purchase options for cheaper, smaller cars have increased as a result, car prices continue to remain relatively high. This means that most Pakistani families are able to afford just one car, if any. Moreover, that car is often owned and driven by the men in the house. Since it is the men who are considered to be the “default drivers”, the boys in the family are “given the car keys” and taught how to drive. For the most part, young girls are not encouraged to learn driving. Even when they do learn, women often do not get the time behind the wheel in a family car that is required to develop the confidence to drive independently. As a result, it is not uncommon on Pakistani roads to find boys far too young to have a driving license driving much older women passengers.

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<sup>32</sup> Prices obtained from Suzuki’s official website as well as car retailers.

Driving on roads is not easy either. The absence of street lights, lack of knowledge about road regulations, and general disregard for traffic rules, combined with lack of enforcement from traffic police means that roads in Pakistan are an example of Hobbes' state of nature, where everyone is in a constant state of struggle against everyone else. Everything from pedestrians to trucks, buses, cars, rickshaws, motor cycles, and donkey carts are vying for space and the right of way on already overcrowded roads. These difficult conditions further deter women from driving, especially those who have learned to drive late in life.

It is important to note that, even though I have focused primarily on the urban areas of Punjab in this chapter, specifically Lahore where I conducted fieldwork, and the experiences of women doctors, the majority of whom belonged to middle and upper class, everyday experiences of mobility for women are intersected by multiple factors like socioeconomic class, age, and geographical location. Class is perhaps the most important aspect to consider. Access to better financial resources means women can afford better and faster transportation, allowing them to commute longer distances. Scholars of mobility, especially in the context of occupational segregation, point out the importance of the friction of distance: At all income levels and for every position, women tend to select jobs that were closer to home compared to men (Hanson and Pratt 1991; 1995; Prat and Hanson 1994). Being closer to home reduces the time bind and makes it easier to manage the dual responsibilities of domestic and non-domestic work, especially important in the case of Pakistan, where an extended family system increases the domestic and care responsibilities of women. Better financial status also provides access to amenities that indirectly reduce demands on women's time, potentially improving their

mobility. For example, many upper and middle class families employ domestic servants, maids and nannies to take care of domestic work, allowing women to cope with the difficult schedule of medical work. On the other hand, women of low socioeconomic status, especially those who are employed as laborers or in domestic work, often have greater mobility because of the need of their employment.

The social status of women is related to security in public spaces as well. Women of the upper and middle classes living in gated communities or posh suburban areas with better street lighting and infrastructure face less threat to their personal security than women living in low income or working class areas. Similarly, women of low social status are perceived as vulnerable in public spaces and thus are more likely to be victims of personal assaults.

Women's mobility also changes over their life course, where young unmarried women face the greatest restrictions, and older women are generally freer to move unaccompanied. This is reflective of the change in women's status within families as well: women's mobility increases as their position changes from the subordinate positions of daughter and wife to the more authoritative position of mother and mother-in-law in older age. Similarly, religious restrictions of purdah and modesty are relaxed in old age as well (Mumtaz and Salway 2005). Finally, mobility of women changes with geographical location within Pakistan. Women in large urban centers have more access to transportation facilities, and are generally more mobile than women in rural areas (Mumtaz and Salway 2005).



## Lived Mobility: Negotiating the Difference

In the discussion above, I have used the categories of perceived and conceived mobilities to stress the social and material dimensions of the restrictions that women face in their everyday movement. I must stress here that in lived experiences of mobility, these dimensions overlap and interact to reinforce each other, as women perceived restrictions on their mobility as intensified by the lack of consideration for them in architecture of public spaces (conceived mobility). Cultural taboos about being in public spaces after dark, for example, are reinforced by a lack of lighting in streets and roads, which in turn increases women's (and their families') fear for their safety. On the other hand, there is little effort on the part of government to improve road infrastructure or to install street lights to make them safer for women, since it is assumed by policy makers that "respectable" women will not use public spaces at night. The disciplinary effect of the constant threat of violence and surveillance is such that women develop a deep seated habitus of feminine bodily comportment and continue to self-govern how they move and behave in public spaces.

These aspects of mobility that I discussed above affect almost every woman in Pakistan to varying degrees, but for doctors (and working women) who need to venture outside their homes, these social and material restrictions are felt most acutely. Their need to be regularly in the masculine and hostile public spaces between their home and work conflicts with the limitations of perceived and conceived space, forcing them to constantly negotiate and even defy these constraints. They have to overcome the cultural and social barriers that lead to expectations that women stay at home or in socially safe

feminine spaces, and must deal with masculine spatial environments that make it difficult to move around on the streets and use public transportation. In the discussion that follows, I focus on the example of a specific mobility practice – driving – to understand how individual acts of active negotiation can re-appropriate and re-contract gendered spaces. I have selected driving because access to a personal vehicle and related mechanical and physical capabilities e.g., the ability to drive and change a tire (Pickup 1984; 1988) can be a crucial step in participation of labor force. These skills and capabilities directly translate into human capital, and change the market position and bargaining power of women (Law 1999). I will be looking at stories of the mobility of women doctors, which represent various types of responses and attempts to navigate through the spatial and cultural (and very much gendered) limitations that restricted their mobility. Women doctors' active appropriation of gendered knowledge of driving and their defiant presence in the public spaces of roads constitutes a counter-public that constantly challenges the gendered notions of mobility.

### **Driving: Negotiating the Gendered Boundaries on Mobility**

Selma's is a familiar story. Her family lived in a small village in rural Punjab. They did not have a car when she was growing up, so she never learned how to drive. During her medical education, she lived on hospital premises in a hostel so there was no need to drive, nor did she own a car (or have the money to afford one). Then, after completing her training, she was offered a better job at a private medical institution, and it soon became clear that she would have to learn to drive if she wanted to continue. Her new workplace was located outside the city, in an area where local transport or rickshaws

were not easily available. Because she was an accomplished surgeon and a professor in a private medical college by that time, it was dismaying for her to realize that, after becoming a surgeon (not an easy task anywhere in the world, but especially daunting for a women in Pakistan), her dream of a career could be thwarted by physical immobility and an inability to drive. When I asked her how she started to drive, she responded wryly, “Well, first I had to buy my own car, you know, so I started saving money.”

Selma is not alone in this predicament. Many of my participants began driving independently only when they were pushed by the need to continue their job, and often the first hurdle they faced was buying their own car. As I mention above, cars in Pakistan are an expensive luxury few people can afford out right. Women doctors, in order to buy their own vehicles, saved money, took bank loans and participated in informal saving schemes (“committees”). For Selma, however, it was a much more difficult affair than simply saving money. Living in an extended family system, both her husband and she handed over their salary to her mother-in-law, who made all the financial decisions. Saving money for a major expense like buying a car required her to first negotiate this economic arrangement, a daunting task in itself. It took her several months of alternate cajoling and bitter fights before she was granted permission to buy her own car. Still, when her savings fell short of rocketing car prices, she had to sell the jewelry that was part of her dowry.

This aspect of driving also highlights how driving is simultaneously gendered and classed. For the few women doctors who belonged to upper class families, owning a car was not a problem, and they often either started driving early or could afford a driver

which made learning it unnecessary. Fareeha, a 40 year old doctor who belongs to a prosperous family, told me that her family owned a car since her childhood. During her education, it was her father who drove her. When she was married, her family gifted her a car as part of her dowry, and she hired a driver for the long commutes to work. “I think driving is a good skill to have and everyone should learn it. I think I just never felt the need to learn,” she told me when I asked her if she ever thought about driving herself, “I use the time during the commute to catch up on my reading.” Belonging to the upper class provided access to better and faster resources of mobility, but this ease of mobility meant that women did not feel the need to contest the gendered norms of driving. This may seem paradoxical, but employing a personal driver is considered a mark of status, and it simultaneously frees time during the commute for other activities, like Fareeha pointed out.

Even when women owned their own cars, learning to drive was a difficult step. Hania, a 34 year old postgraduate trainee, commuted for six years on a rickshaw to work before she managed to save enough money to buy her own car. She did not know how to drive it, though, and so she had to hire a driver. After paying for childcare and driver, as she put it, “I was empty handed for the rest of the month.” To make the matters worse, the driver she hired was very unreliable, often taking leave without informing her, so she decided to learn herself. Her husband, however, strongly discouraged her, telling her that she should not learn, and she will never be proficient enough to drive alone. When I asked her why, she explained,

People don't want their wives to learn driving because they become *independent*. Because a husband thinks that if his wife doesn't know how

to drive, she is *dependent* on him. She will have to ask him for clothes, for schooling of kids, for coming or going anywhere. And he will say no twice, may be make (disapproving) faces a third time, and finally say yes the fourth time, and so she will have to feel obligated to him.

It is interesting to note here that these negotiations and confrontations are not about being mobile, or moving in public spaces per se. These women were already working and as such already “moving” between their work and home. As Hania’s quote hints, it is the symbolic meaning of mobility that is at stake. A women learning to drive herself signifies unaccompanied, potentially unhampered mobility, independence and freedom, something that is considered part of masculine identity. Driving does not just enhance physical mobility, but challenges perceived mobility expectations about women. That is also the reason why, in many families, men chauffeur the women to schools, to work, to doctors, everywhere (whether they like it or not) since it gives them a degree of control over “their” women. It makes men the guardians of mobility, and hence of the honor of women. Driving (and driving women) becomes intertwined with masculinity as much as immobility is associated with femininity. Beginning to drive thus signifies an act of an active intending subject who, using whatever means at hand, not only appropriates the physical material space, but also re-negotiates symbolic gendered spaces.

Driving is an activity that requires a great deal of practice and training to master, especially under the difficult driving conditions of Pakistan. It requires extensive physical training (to be able to control the gears, steering wheel, breaks and clutch paddle simultaneously) and the building of driving reflexes overtime to be able to understand and react to driving conditions. For women who were starting to learn, after years of being told that they were not supposed to drive, it was a huge transition that required time

and effort. For women doctors already feeling the squeeze of a second shift at home and a demanding profession, carving out time for this additional work was even more difficult, forcing them to be creative. They used their summer vacations when their schedule was more flexible and practiced driving when the kids were sleeping or at school. It still took them a long time to feel at ease on the road. When Selma eventually managed to buy her own car, she realized learning to drive would not be an easy job either. Her memory of learning to drive illustrates multiple dimensions of the restrictions on women's mobilities and her struggle to overcome them:

At first I considered joining a *driving school*, but being in a car with *male instructor* was not acceptable for my husband so he decided to teach me himself. Fortunately, it was summer and I had some time, so I practiced *driving* every day. I had to ask my husband or my mother-in-law to watch the children while I practiced.

Since Selma was learning driving only to be able to go to work and pick up her kids, she spent the whole summer practicing on the route to her workplace. Despite this constant practice, when her job started, she was still not confident enough to brave the heavy traffic during rush hours. To avoid it, she left several hours before her shift actually began and waited at the hospital when it ended. Difficult driving conditions compounded with overcrowding on Pakistani roads make driving a daunting task. Women drivers who have learned only recently still face difficulties on the road, as they do not drive in areas with heavy traffic or use longer routes to bypass them.

The (gendered) perception that women are not good drivers and are unable to navigate difficult traffic can deter accomplished women drivers as well. Nabeela, a 36 year old surgeon, learned driving from her brother when she was still completing her

training and was still unmarried. Her parents lived in a gated community which had very little traffic, so it was relatively easy for her to drive in that area. However, when she got married, her husband lived in the inner city, where narrow congested roads are more common. Her husband refused to allow her to drive, insisting on driving her, since he considered the area too dangerous for her and he was not sure if she would be able to navigate in that traffic. Both her husband and her job had unpredictable schedules, however, and it made this arrangement very difficult for her. Her story of beginning to drive demonstrates her frustration and finally her refusal to accept her restricted mobility:

Once my husband got delayed at his office, and he didn't come to pick me up. I waited quite long, but on each call he kept saying, just another hour. Finally I got tired of waiting for him. I said, what the hell, I will go myself. I took a rickshaw and I went home. By the time I got home, I was really angry. So I said to him, I will show you that I can drive. I took the car outside, alone. Before that he did not let me drive in that area without him. After I started, I realized that I could drive easily. He had me frightened for no reason, saying that you can't drive here, you are accustomed of driving only in suburbs and you will cause an accident.

Her defiance did pay off, since after seeing her determination, her husband allowed her to drive alone after that time. And women doctors need to be defiant both inside their homes and on the roads to challenge gendered notions of mobility. Women drivers in Pakistan, like any other country, face the brunt of bad driver stereotypes, perhaps intensified because so many of them are relatively new drivers. They also face aggression at the hands of fellow drivers on the roads. However, by their presence on the roads, women also challenge the masculine construction of public spaces, even defying the norms of feminine behavior. Selma, though an expert driver by now, still has difficulty in changing lanes often or forcing her way through the congested intersections. Many times this creates problems for her on the road but she has learned to shrug it off,

as she told me, “If there is a slow vehicle going in fast lane in front of me, I don’t try to overtake it by forcing my way through. But people behind me don’t realize that, and then if they flash their head lights at me, I don’t bother. I think well if you are in such a hurry, why don’t you try and pass this rickshaw.”

Arshia, a young driver, was regularly harassed by a man riding a motorbike on her way to work. For a while she tried to ignore him, but that did not work, so one day she decided to take a different approach, “I realized that he was on a bike and I am in a car, so I am much safer. When he suddenly drove in front of me trying to force me to slow down, I did not break speed. He was so scared that he never bothered me again.” Though this unexpected and rather unfeminine act of aggression worked, it takes an immense amount of courage to face these challenges on daily basis. Ammara, 55 years old, started driving when few women drove even in a large urban city like Lahore. She continually faced harassment on the roads. Drivers who passed her by honked, made lewd comments and gestures, even to the point of threatening her safety by driving too close to her. It was her husband who comforted her when she felt overwhelmed by telling her that others were merely threatened by her presence and that she could not let the attitude of few bad people drive her spirits down.

Learning the drive, however, has its own consequences. So far I have discussed how increased mobility, thanks to driving, enabled women to participate in the workforce, change the gendered construction of public spaces, and renegotiate familial relations. On the other hand, being able to drive also changes the distribution of the workload within the household. In the traditional family (and mobility) structure, men



took on work that required driving (buying groceries, paying bills, chauffeuring children, as well as accompanying women on their frequent social trips). As women learn driving, men become reluctant to do these jobs. Though driving increases women's geographical mobility, it paradoxically reduced their freedom to move by increasing the demands on their time. Shahida, a 35 year old doctor, learned to drive like many other participants, to be able to work and to manage her time better. However, increasingly she found herself being responsible for more and more work both outside and inside the house. Like many other Pakistani families, she is responsible for almost all domestic work, like cooking, cleaning, washing and ironing. Now, she also has to pick up and drop off her children, do household shopping and accompany her parents-in-law to their various social and medical appointments, most of which was previously done by her husband. Rather than freeing up her time, she is much busier now. On the other hand, free of domestic responsibilities, her husband is able to work more hours. "Sometimes I wish I had never learned driving," she told me bitterly.

### **Changing the Limits/Limits of Change**

Thus far, I have discussed the examples of women who in various ways (by buying their own vehicles, learning to drive, and eventually, driving on the roads) challenged and negotiated various gendered social and material structures which restricted their mobility. I have presented their stories in order to point out the ways in which women doctors must negotiate the complicated web of family structures, gendered conceptions about their mobility, and the hostile environment of public spaces. It is

important here to understand what (if any) change these individual acts wrought in the overall social and cultural schema of mobility and gendered relations, on a macro level.

For one, it is no longer an uncommon sight in large Pakistani urban centers to see a woman behind the wheel. It no longer invites the stares of onlookers. By their sheer number, women have made driving more or less socially acceptable for themselves. Many driving schools now offer women instructors to facilitate women drivers. Suzuki, a multinational company, aired the first automobile advertisement directly marketing cars to women drivers. Another important aspect is how women's increased independence and individual mobility changes gendered ideologies of mobility within their families. Faiza, a 55 year old doctor, for example, learned to drive to chauffeur her children and parents-in-law. When her two daughters, both of them also doctors, started their careers, she knew how important driving would be for them and taught both of them. Kokab, another woman doctor, was allowed to enroll in a women-only medical college. She allowed her daughter to join a co-educational institution, even though her family was against it. This decision to invest in the mobility of daughters is in clear contrast to gendered expectations of mobility for women in Pakistan.

On the other hand, this does not mean that women in Pakistan now have perfect freedom of movement, as many gendered ideologies about the mobility of women continue to remain unchallenged. For example, even though driving is much more socially acceptable for women, other cultural and religious taboos like going out at night, familial restrictions on the unaccompanied mobility of young unmarried girls, and the gendered distribution of financial resources and work within the family (that profoundly

affect women's experience of space and time) still remain. Similarly, this change has occurred only for a few educated women of a particular social class living in urban centers, while for many more women, constraints on mobility remain largely unchanged. Women of lower social status who do not have access to transportation facilities, but need employment to support their families, are particularly vulnerable to this marginalization. There is, however, little effort on the part of the state to address the needs of women travelers through concrete policy change or infrastructure development.

Similarly, even though women are able to resist and negotiate the structures of mobility individually and with their families, patriarchal perceptions about the place of women remain unchanged. "Women's question" still remains the center of defining a uniquely Pakistani identity, perhaps even more so in the aftermath of US intervention in the area, and the neocolonial mission of "saving the Muslim women" (Charania 2014). Consequently, as the number of women in public spaces increases, they are more susceptible to surveillance and disciplinary social control. They have to be more vigilant about their bodies, their dress and their actions in public spaces, not only for fear of sexual harassment, but also to look like respectable Muslim women.

More importantly, as Abu-Lughod (1990) points out, subverting traditional and local structures of authority simultaneously opens up women to newer, more pervasive, global relations of power: Driving and ease of mobility increases women's participation in the workforce, but also enmeshes them in complex networks of economic and institution powers by facilitating their insertion in the project of capitalism as consumers and laborers. As women doctors take on extra work outside their homes, the unequal

distribution of work between men and women inside the home remains. Learning driving for example, helps them in continuing their work or enables them to apply for better job, but also increases their domestic workload and the work/life conflict they experience, as they have to take on work that required driving (and thus was previously in masculine domain). The intersection of patriarchy and capitalism results in different spatial distribution of women's work, but as the experiences of mobility of Pakistani women doctors indicate, this difference does not always translate to more empowerment, equity or justice.

## CHAPTER 6

### DOING GENDER, MODESTLY: INFORMAL WORK-PLACE RELATIONS IN MEDICAL WORKPLACES

#### **Gendered Interactions**

Afridi Hospital is one of the largest teaching hospitals in South Asia. Its old sprawling buildings are nested among some of the oldest bazars and busiest roads in Lahore. In the past year or so, I have grown to know the constant rhythm of activities on these roads, the ebb and flow of traffic and almost constant wailing of ambulance sirens. Ever since a bomb blast in a public park in Lahore on March 27, 2016, security has been tightened everywhere. There is barbed wire fencing all around the hospital buildings, and a couple of guards at the main entrance who stop everyone and ask to see an ID card. Sometimes if a person seems suspicious they keep the card until the owner returns. Upon entering, I tell the guard I am visiting the surgical ward. “Okay Doctor Sahib,” they say as they wave my rickshaw inside. It is early in the morning, a relatively quiet time. The outpatient department will not start working for a couple of hours, but patients, especially those who came from outside the city, have already started lining the corridors, waiting to be seen by a doctor. A new shift has started in the emergency room, and as a fresh group of doctors and nurses take over, the patients admitted overnight are being rolled out on gurneys to be transferred to in-patient wards in the main building. Inside, the corridors are filled with patients’ visitors. It is customary in Pakistan for whole families to accompany patients to the hospital. Some of these visitors cannot afford accommodation in Lahore, and they spend the night camped out in the corridors, as well as along the roads and on benches in a nearby garden.



Figure 7. Patients and their Attendants Sleeping in a Courtyard



Figure 8. Patients and their Families Camping outside a Public Hospital

I am meeting, Dr. Rubab today, a surgeon and a senior registrar<sup>33</sup> in the surgical ward. It is part of her duty to do an early morning round to assess the patients admitted overnight from the emergency room, and to select the patients who would be “on the list” (meaning they would be operated on today). As I join her, Dr. Rubab is making the rounds accompanied by a young woman house officer, who is “presenting the cases,” as they are called. At every bed, she states a brief history of the patient, examination findings and treatment plan, usually in English. Patients lying on the beds hardly understand a word of what is being said about them, because they often do not understand English or medical jargon. Dr. Rubab asks frequent questions in English, usually directed at the senior medical officer, who is responsible for the treatment of patients as well as training the house officer. Occasionally, she confirms something from a patient in Punjabi. This code-switching is meant to reinforce the power relations between an educated, upper class, all-knowing doctor and a lower class, helpless patient.

Last night was what doctors call “a heavy emergency.” The ward is already filled beyond its limits. Pakistan reserves less than 1% of its annual budget for health related spending, and it shows in the condition of country’s public hospital. Originally designed for far fewer patients, many more beds have been crammed in the small space. Nearly 7,000 patients visit Afridi Hospital daily, which has an official capacity of 2,400 patients. The verandas outside, which originally looked over a garden, are converted to makeshift wards with beds lining their walls along with the old, moldy filing cabinets. Even then,

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<sup>33</sup> A management position in the hierarchy of wards. Registrar looks after day to day to working of department, posts duties and assigns patients.

the nursing staff has to assign two, sometimes three patients to one bed, lying with their feet beside another patient's head. Those who can walk (stable and ambulatory, in hospital's parlance) are told to take a walk, and leave their records on the bed, a paper file that holds the place for a human body. There are no curtains between the beds, and no private examination rooms. If patient is a woman, the doctor would examine her under her clothes, or create a shield of sorts with her *dupatta* (long head scarf). Otherwise, wounds are exposed and dressed, tubes are inserted and taken out, and examinations are done in the plain sight of everyone. In this public hell, only pain is private.

The group of doctors surrounding a patient's bed is an equally interesting sight. While many of the young doctors and students are women, the majority of the senior surgeons are men. This is in marked contrast to other departments, where women doctors have a substantial presence. Though on the surface, the group of doctors huddled around the bed, standing on their toes and trying to look over the shoulders of others seems disordered, there are quiet subtleties in the interactions betraying the hierarchies in the organization of this department. Dr. Rubab, being the registrar, is the most responsible person in the group, so everyone is differential towards her. Students and doctors are careful to address her with a respectful "Ma'am". The junior professor doing the round, who is a man, is in an awkward territorial contest. Being a consultant he is senior, but being a registrar, Dr. Rubab is responsible for patient care and assigning duties to doctors, and her position indicates that the head of department trusts her. There is one patient with a huge swelling in her neck and the junior professor wants her to be on operating list for surgery tomorrow. Dr. Rubab disagrees, because the thyroid has a retrosternal extension, that is, part of it is in the chest, and it would take 8 hours to



operate. There are only four tables in the operating theater, and keeping one table occupied this long will create a huge backlog. The patient can wait, Dr. Rubab respectfully suggests, careful not to offend him. The professor shares the evening practice with the head of department, and the news of her being disrespectful to a man senior professor will travel fast. He agrees grudgingly, but the mood of the round has soured.

A silent look passes, as students shuffle to stay out of sight to avoid being singled out for the questioning. Professor signals to a woman student on the outside of the students' circle, who is wearing a veil, and asks her a question, "Come, stand in front, I can't even tell if you are sleeping or yawning underneath your veil," he tells her. Half way through her answer, he interrupts, "Speak up! I can't even understand you behind all that cloth." On the next bed, he asks a woman student to do a percussion.<sup>34</sup> She moves next to the patient's bed, carefully remembering all the steps, which involve asking for consent, warming your own hands, and inquiring about pain. But her percussion is not loud enough. The professor demonstrates the correct way, and the participants of the round listen to appreciate the subtle differences in sound. He shows the correct placement of fingers, the movement in the wrist. But the student is still not doing it correctly, and being a man, the professor cannot hold her hand to show her. Exasperated, he turns to Dr. Rubab, the only senior women in the round. She holds the woman student's hands and shows her how to loosen her wrist joint. The student is instructed to find a "stable

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<sup>34</sup> A technique of medical examination, where surface of body (usually skin) is quickly tapped to listen to the sound produced and assess what is underneath it.

patient” and practice until she has a callus on her finger. Satisfied that his authority is now reasserted, he allows the rest of the round to go on in relative peace.

Hospitals are like a microcosm that reflects the social relations operating in broader society. Although, strictly speaking, the workplaces of women doctors extend far beyond the premises of a hospital, since their work both as a doctor and as a woman takes place in multiple spaces, Pakistani hospitals do provide a glimpse into the intricacies of personal interactions, allocation of resources, design of organizational spaces and differentials in symbolic capital, which significantly affect women doctor’s experiences. The interface of gender and organizational work is an active focus of research (Ridgeway 2001; Padavic and Reskin 2002; Britton 2000, 2003; Martin 2003; Ward 2004). Research on organizations problematizes the view that organizations and work environments are ostensibly gender neutral, asserting that job descriptions, processes and hierarchies within bureaucracies of current organizational environment are inherently gendered (Cockburn 1985, 1991; Acker 1990, 2006; Britton 2000). Social interactions and work relations form an important dimension through which organizations become gendered (Acker 1990, 1992, 2006). Participation in work-related, informal relational networks not only mediates access to information and resources, but also helps in integration in the workplace and career success through mentoring, emotional support, advice and expressive networks (Kanter 1977; Granovetter 2005; Brass 1985; Ibarra 1993, 1992, McGuire 2002).

However, work related relationships and their gendered implications for career and success are primarily investigated in Western contexts. Little is known about the organizational culture and gendered work-related informal interactions in Pakistani

society (or Muslim majority societies in general) where relationships between men and women are subject to myriad of cultural and religious taboos (with some notable exceptions for example Syed, Pio and Ali 2013; Syed and Ali 2013). Especially significant in this regard are the norms of hijab/*purdah* (which I discuss below), a complex system of practices and beliefs related to modesty, honor and gendered social relationships which constitute an important dimension of the lived experiences of both men and women in Pakistan (Papanek 1971). As the vignette above shows, these modesty related restrictions can significantly affect women doctors' experience of their workplace.

In this chapter, my aim is to understand how women and men doctors relate to each other informally in Pakistan's medical workplaces in the presence of the customs of hijab/*purdah* and modesty, and how the practice of *purdah* affects the informal relationships and career success of women doctors. To this end, this chapter is organized as follows: First, I discuss how workplace interactions between men and women doctors are affected by the norms of *purdah*. I focus on how norms of *purdah* affect the organization of public spaces (and workplaces), the dress of women doctors and their interpersonal interactions and language. I also discuss how their interactions are mediated and restricted by these norms. Second, I discuss the narratives of women doctors who practice different forms of *purdah* and how they experiences of the workplaces differently because of their varying practices of modesty.

### **Conceptualizing Purdah**

*Purdah* or hijab is a system of gender based ethics of interaction practiced in Pakistan and to some extent other south Asian and Muslim societies. The norms of *purdah*/hijab, a social institution that ensures modesty and honor for both women and

men in Pakistani society, intimately encompass and control every relation between men and women, men and men and women and women. Before I go in further detail, I want to clarify some of terms that I use throughout the following discussion.

Hijab is a social system that ensures modesty and honor in the interactions between genders that is based on the religious precepts of Islam.<sup>35</sup> *Purdah* is a gender

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<sup>35</sup> It is pertinent here to briefly mention various verses of Quran which are quoted by Muslim religious scholars in support of hijab. I am mentioning these verses specifically to point out that practices of hijab extend far beyond the Muslim feminine dress code:

Tell the believing men to lower their gaze and guard their private parts. That is purer for them. And tell the believing women to lower their gaze and guard their private parts and not expose their adornment except that which [necessarily] appears thereof and to wrap [a portion of] their head covers over their chests and not expose their adornment except to their husbands, their fathers, their husbands' fathers, their sons, their husbands' sons, their brothers, their brothers' sons, their sisters' sons, their women, that which their right hands possess, or those male attendants having no physical desire, or children who are not yet aware of the sexuality. And let them not stamp their feet to make known what they conceal of their adornment. (24:30-31)

And (as for) women advanced in years who do not hope for a marriage, it is no sin for them if they put off their clothes without displaying their ornaments; and if they restrain themselves it is better for them. (24:60)

If you fear Allah, then do not be soft in speech [to men], lest he in whose heart is disease should covet, but speak with appropriate speech. And abide in your houses and do not display yourselves as [was] the display of the former times of ignorance. (33:32-33)

[To Muslim men] and when you ask [women] for something, ask them from behind a hijab i.e. a partition. That is purer for your hearts and their hearts. (33:53)

There is no blame upon women [regarding their social interactions] concerning their fathers or their sons or their brothers or their brothers' sons or their sisters' sons or their women or those their right hands possess. (33:55)

And finally:

based system of seclusion, mobility restrictions and avoidance that is practiced across South Asia, which in the case of South Asian Muslims, is based on the Islamic codes of hijab.<sup>36</sup> Since in this chapter my focus is on this local practice of hijab (i.e. *purdah*), specifically in the context of Muslim women of Pakistan, I use hijab and *purdah* synonymously (both *purdah* in Urdu and hijab in Arabic literally translate as “curtain”)<sup>37</sup>. Moreover, my participants also used both of these terms interchangeably to describe their practices of modesty in various contexts.

Another important clarification is that prevailing research on hijab solely focuses on its most visible and political symbol, that is, various feminine codes of dressing like

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O Prophet, tell your wives and your daughters and the women of the believers to bring down over themselves part of their outer garments. That is more suitable that they will be known and not be abused. (33: 59)

<sup>36</sup> As such, *purdah* is practiced by both the Muslims and the Hindus, though the practice differs greatly between the two groups. In Muslims, the interactions between women and her non-kin men is limited, and the strict enforcement of restrictions begin at puberty. In Hindus, *purdah* is used to indicate social distance between a women and her affine, and the restrictions begin usually after marriage. Moreover, Muslims derive the rationale for *purdah* from the religious codes of Islam, while the origin of practice of *purdah* in the Hindus is debatable issue. Some scholars suggest that practice of *purdah* was adopted by Hindus to gain social status in response to dual colonization by the Muslims (who practiced *purdah*) and subsequently by the British (with their Victorian ethics of modesty).

<sup>37</sup> Although curtain might be understood as a metaphor for hiding, it is not completely accurate. Curtain (in case of hijab/*purdah*) is used to denote the separation between men’s world and women’s world (both inside the household and outside of it). This separation and distance is to ensure that during their interactions both men and women remain modest and chaste. Another significant point in this regard is that head covering is prescribed in Quran specifically to make Muslim women visible and recognizable as Muslims (i.e. as a symbol of Muslim identity) and not to hide them or make them invisible. (see Quran 33:59 where prophet is advised to command Muslim women to draw their garments over their head “so they are recognized and not harmed”)

headscarf and veil, to the extent that hijab has become almost synonymous with these garments. This has important consequences. For one, it leads to the misconceptions that hijab/*purdah* related codes of modesty are only for women, since this visible symbolic dress is almost exclusively associated with women, and *purdah*/hijab as it is practiced by men, or how it affects interactions between men and women, is left almost completely untheorized. Secondly, the emphasis on the garments that have come to symbolize hijab means that other aspects of hijab/*purdah*, including how these practices are institutionalized in Muslim countries, particularly Pakistan, through gender segregation policies implemented by the state, and the importance of *purdah* related practices for the lived experiences of Muslim men and women is not completely understood. To counter that, I have used the term *purdah* in this discussion to denote the variety of practices of hijab (not just dress) by Muslim women in Pakistan. In that sense, *purdah* is better understood as a deep seated habitus (and a specific gendered subjectivity) produced through socialization, spatial organization, and a myriad of bodily and dressing practices and the control of gaze and voice (rather than just a dress or gender based segregation). In fact, “doing *purdah*” is almost synonymous with how gender is “done” in Pakistani society in social interactions (West and Zimmerman 1987; 2009).

I should specify here how this discussion connects with the extensive debates related to the veil (as the dress code of hijab) within academic research and Islam itself. Although many mainstream Islamic interpretations of Quran and hadith (two major sources of Islamic jurisprudence and code of conduct) suggest that “good” Muslim women practice some form of hijab (Afshar 1985), the specifics of the practice (such as hijab of voice, hands, feet and face) are deeply contested among various Muslim schools

of jurisprudence. Muslim feminists also challenge the interpretations of Qur'anic edicts by traditional Muslim theologians: some by emphasizing the patriarchy being read into the interpretation of Quranic edicts (Merssini 1987; 1991; Fernea 1998; Barlas 2002); others by highlighting the empowering potential of the veil by providing an avenue for Muslim women for participation in public sphere by remaining modest (El Guindi 1999). More recently, Leila Ahmed (2014), Leila Abu-Lughod (2002), Saba Mahmood (2001) and Zillah Eisenstein (2002) have critiqued both of these narratives, which either portray the veil as a stand-in for imposed religious patriarchy on Muslim women, or romanticize its woman-friendly adaptability. They emphasize the need to account for the common underlying assumption of liberal-secular modernity as the ideal, and to ground the empowering (or oppressive) role of such practices in the lived experiences of those who are directly involved in it. My analysis to some extent borrows from this last perspective, as I make no *a priori* assumption about the empowering potential of *purdah*. I am also not concerned with the religious politics of the veil, nor its global significance for Muslim identity, for instance, in other countries like in Europe. Instead, I try to trace connections between women's experiences and discursive practices of Pakistani society related to gender, of which *purdah* is an example, and their experiences in workplaces.

### **Purdah and Informal Workplace Relationships**

Research on organizations differentiates between two types of organizational relations, formal relations, which are prescribed by organizational structure, and informal relations that extend beyond the formal structure as people interact and form relationships during the course of their work (Ibarra 1992). It is these informal interpersonal relationships between seniors and juniors and between peers that are particularly

important for career success, job satisfaction, skill acquisition, and career mobility within workplaces (Burt 1992; Podolny and Baron 1997; McGuire 2002). Particularly in the context of Pakistani organizations, knowing someone informally is usually a prerequisite in order to cut through a lot of red tape, to get correct and timely information, and sometimes just to get inside an office, as my participants often said “it is the relationships that get things done (*talluqat pe hi kam hota ha!*)”

Since *purdah* is directly related to the social interactions between different genders, its norms and considerations are immensely important in the workplace relationships of women doctors. Research in Western contexts indicates that women often face challenges in their careers because of limited access to or exclusion from informal networks in workplaces (Ibarra 1992; 1993; Smith-Lovin and McPherson 1993; McGuire 2000; Moore 1992). These gendered differences in workplace relationships can be because of differences in socialization, behavior, personality characteristics or personal preferences between men and women (dispositional perspectives) or because of contextual constraints and dynamics of organizational culture which create obstacles in women’s workplace relations (situational perspective) or both (Riger and Galligan 1980; Downey and Lahey 1988; McPherson and Smith-Lovin 1993). *Purdah* and norms of modesty contribute significantly to all three of the aforementioned aspects of work place relationships.

In the discussion that follows, I will discuss various aspects of practice of *purdah* in Pakistan’s medical workplaces, and how they affect the interactions between men and women workers. Before I begin, I want to stress that the particulars of *purdah* as it is



individually practiced vary a lot by multiple intersecting factors like age, class, educational status of women and their families, occupation, geographical location (urban/rural; and in various provinces of Pakistan), religious and sectarian affiliations, and personal life circumstances. However, it is the existence of *purdah* as a social institution in the society and its effect on social and material structures that makes it a significant component of women doctors' experiences (Papanek 1971; 1973)

### **Separate Worlds: Purdah as Spatial Segregation**

The organization of the public spaces like hospitals is a good starting point to understand the customs and prevalence of *purdah* in Pakistani society, since the gendered assumptions regarding the interactions between men and women are often physically written in the material architecture of public space. The gender based segregation<sup>38</sup> of public spaces has its roots in the colonial history of India, where the British Raj in its attempt to reform “native” Indian women, created gender segregated medical and educational institutions, thus for the first time institutionalizing *purdah* through state policies.

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<sup>38</sup> The segregation should not be understood as something monolithic and absolute. Though as I discuss spaces are segregated by designating them masculine or feminine, in practice there is a lot of movement across these boundaries (which also depends on how strictly the segregation policies are enforced). In women's only institutions for example, while students are all women, some men teachers and staff may be present. Similarly, gender segregation in Pakistani hospitals is a little different. While wards for men and women patients are separate, men and women doctor, and nurses (who are almost always women) work in both ward (so in wards patients are segregated but medical staff is not). In contrast, duty rooms and offices for men and women doctors are segregated, but patients of either gender can approach them.

Today, most public spaces in Pakistan are either physically segregated (by creating separate facilities for men and women) or segregated in effect (by stipulating different times for the use of men and women). All public educational institutions (except universities and professional colleges) are segregated by gender. Women only universities and medical colleges are an extension of this social norm. Even in co-educational medical colleges, women and men remain practically segregated (though the walls here are invisible, as they sit on the opposite sides of the class room). Businesses including banks have separate counters for women, especially in urban areas. Some banks have established separate branches only for women's use. Parks, gyms and recreational facilities have specific times reserved exclusively for women. NADRA (the government agency for issuing identity cards) and Driving License issuing authorities have reserved a "ladies' day" so women can get their document easily. In all public transportation facilities there are separate compartments set aside for women, or women can request that no man be seated beside them.



Figure 9. Respectable Distance: Men and Women Medical Students in Separate Study Groups in Dissection Hall of a Public Medical College

In Pakistani hospitals, similarly, there are separate wards, examination rooms and waiting facilities for men and women patients and gender segregated offices and duty rooms for men and women doctors. Because of this, women and men doctors are excluded by definition from each other's company. In the medical department of Afridi Hospital, for example, women and men doctors have separate duty rooms, where doctors sit during their duty hours, add patient notes, prepare lectures, have tea or lunch during break, and sleep during night shifts. If a man doctor or a patient needs to talk to a woman doctor (and vice versa), they knock and ask permission before they can enter the "other's space", and leave as quickly as possible when their business is done. Having a space of one's own is convenient in many ways: women doctors socialized with each other, helped their juniors with their patients and shared gossip and information. Those who wore a veil

could take it off here and eat freely, while those who did not put their feet up, took off their *dupattas* and relaxed. On the other hand, the majority of the senior doctors in this department are men, and they are more involved in the decisions making and distribution of resources in the ward. However, since they congregate in the men's duty room, women are often excluded from these informal meetings. Dr. Farrukh, a junior woman doctor in the department, told me:

In the ward and during the rounds, all of us doctors are together, but after that my men colleagues go and hang out with professor in his office or in the men's duty room. They chat, discuss research ideas and decide who wants to write a paper together. We cannot be a part of that. We cannot be friendly to them like other men. It is just not in our training. We work just as hard in the department, but if a new research opportunity comes along, it's a man who is asked to participate.

This phenomenon is not specific to workplaces segregated by *purdah*: Research on the personal networks of women in organizational contexts in Western societies similarly indicate that most of their ties and informal connections are likely to be with other women, a phenomenon called gender homophily (Ibarra 1992). Since women are less represented in higher echelons of power in many organizations, women will have few, if any, instrumental connections with people who control the nexus of knowledge/power (McPherson and Smith-Lovin 1982; Ibarra 1993; 1995). As a result, women academics and students in STEM fields (where the number of women has been historically low) often report feeling isolated, or invisible (Kemelgor and Etzkowitz 2001; Pololi and Jones 2010). Dr. Hira, another medical officer in the same department explained:

I think we *female* and *male* doctors are colleagues and in that sense there is no difference. But then *male doctors* have a closer connection with the seniors (who are also men). Last week, all the *male doctors* of our *ward*

were invited to our (man) professor's home. Yesterday, my *male colleague* brought a box of special sweets that our professor apparently really likes. I did not even know about that because I am not *friendly* with our professor. I feel like they are *closer*, like part of a family. And we women are not.

Increasing the representation of women in medical workplaces does not problematize this segregation. While the ownership of space may change (the duty room is a “masculine” space in departments with a majority of men, and a “feminine” space in departments with a majority of women), the barrier of *purdah* remains unchallenged. This has important consequences for both men and women doctors. In surgery department, where men are in majority, it is the few women surgeons who feel isolated and left out of the conversations at the workplace. In the gynecology department on the other hand, it is the few men doctors who are left isolated: When woman doctors were sitting and talking in the duty room, men doctors simply peaked inside and left quietly. On another occasion, once the conversation between a group of women doctors turned informal, a man house officer writing patients' notes in a corner simply got up and left (I found him later, finishing his work at a nurses' station).

Importantly, both men and women are equally involved in policing the boundaries of these segregated spaces (sometimes rather literally, as the doors of women wards were guarded by paramedical staff, who forbid the entry of any men inside the feminine space). Dr. Khalida, a young house officer, had a 24 hour work shift in the Pediatrics ward with a fellow house officer and a supervising medical officer (both of whom were men). During the night, her fellow men doctors ordered pizza and practiced history taking and examination methods in men's duty room, while she sat alone on women's side. Next

week, she decided to join them in study on men's side. However, her transgression was immediately noticed:

People around the ward started *gossiping* immediately. I am here to work and I do not want any slur on my character so I decided then and there that I will not do it again. But then our head of department called me to his office, and reprimanded me for going in men's duty room. Then our registrar put me on weekend 36 hour duties for the whole month as punishment.

This particular segregation of spaces resulting from the customs of *purdah* in Pakistani hospitals particularly affects the workplace relations of women doctors, who then have difficulty in accessing knowledge and material resources, advice and career guidance from their men colleagues.

### **Veil and its Variants: The Symbols of *Purdah***

Perhaps the most obvious symbol of *purdah* is its myriad of dress codes. A long, rectangular piece of cloth (called *dupatta*) is part of routine, everyday feminine dress in Pakistan, and those practicing a less strict form of *purdah* usually just wear *dupatta*, often draping it over their heads and/or chest. Like the veil, there are many individual variations in the wearing of *dupatta* as well: some wear a *dupatta*, coordinated with their dress (especially in front of elders and non-kin men at home), other wear *dupatta* of a thicker material, usually in a neutral color, called *chadur*.<sup>39</sup> There are infinite variations

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<sup>39</sup> The terminology used for the hijab/*purdah* related garments is bafflingly extensive, for these garments and their names vary in different cultures. Moreover, as part of a global community of consumers, women adopt styles from across the world. It means that one term can indicate different garments in different areas and vice versa. For example *chadur* means a rectangular piece of cloth draped over head, neck and shoulders in Pakistan; a cloak like garment that covers a woman from head to toe but leaves face uncovered in Iran; and a cloak like garment that covers face including the eyes in Afghanistan. Similarly, the word hijab can be used for a headscarf that covers head, neck and shoulders but does not cover face, a headscarf that covers face as well, and for the

of this dress code depending upon personal preference of the wearer, which serve as a marker of the wearer's class (more ornate, decorated styles versus more traditional styles), religious and sectarian identity (different variations worn by women connected to *Jamat-e-Islami* or those belonging to Ismaili or Ahmadi sects), and interestingly enough, a global citizenship (many variations are inspired and imported from Egypt, Iran and Saudi Arabia). Furthermore, the practice of wearing these garments, and the practice of *purdah* is not constant in individual practice. Rather, women adjust their garments and their practice of *purdah* according to the need of the occasion and to communicate distance, kinship and social status. A woman, for example, may take off her scarf altogether in the presence of her immediate family, wear a *dupatta* or cover her head in presence of elders, wear a *chadur* in market and a headscarf to her workplace.

The dress of women doctors exemplifies infinite variations on this dressing theme. The dress of doctors mirror the hybridity of their identities as modern, Muslim Pakistani women, who are modern without being essentially Westernized, and confident and feminine in public spaces. As doctors, educated and professional women are distinct from other women of the lower classes and women of previous generations. A few combine their white lab coat with *dupattas* and headscarves. Others use only a headscarf (occasionally a headscarf with veil) without the *dupatta*, which frees their hands to examine the patients. A few younger students forgo *dupatta* altogether (considered a serious breach of tradition until recently, but increasingly common now). Still others pair

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social customs of interactions more broadly in various contexts. Since this discussion is specifically in the context of Pakistan, I use the names and description of the garments as they are used in Pakistan.

their lab coats and headscarves with jeans and a t-shirt (also not very commonly worn in public by women, but now increasingly common).

These individual variations are not just a matter of personal preference, each of these variations of dress act as a symbolic code in the game of religious, class and ideological signification. Consequently, a woman doctor (and to some extent men doctors too) with a specific dress (and practice of *purdah*) is also expected to conform to the behavioral expectations of that class, identity and religiosity. During classes and wards, some men students avoid directly speaking to a woman student who wears the veil. Woman students and doctors similarly know about their men colleagues who do not talk to women and avoid speaking directly to them. Moreover, the behavior of both men and women is doubly surveilled if their dress marks them as observant of *purdah*: first, by those who practice *purdah* themselves and expect other observers of *purdah* to conform completely to the behavior expected of them, and hence adhere to it strictly in all occasions; and secondly, by others who do not wear the veil, but are quick to point out any misstep of those who do. Hence, a woman wearing a veil draws stares if she seems friendly with another man, or she suddenly decides to change her practice of *purdah*.

Tanya for example is a young woman doctor who wears a veil with her white lab coat. One day her long braided hair was left hanging below her headscarf. Tanya told me, “A senior doctor came to me and she tucked my hair beneath the scarf, and then patted me on head and said, ‘You practice such good *purdah*. Do not let your hair be visible. They are also to be hidden.’” Tanya was taken aback. She wore the veil as a symbol of modesty, and had no idea about the theological debates of covering the hair, but after that she had to be careful. Similarly, Farhat a young doctor usually wore a headscarf to her



department since she found it more convenient than a *dupatta*, which, as she told me, “keeps slipping here and there and gets in the way.” In a formal conference, however, she wore a *dupatta* instead of headscarf, and that did not go unnoticed, as she tells:

I swear, almost every person in the ward came and commented on it, like ‘Oh! You look so different, or so much better.’ A couple of people came to me with serious intentions to preach, thinking that I have stopped practicing *pardah*. Then, the next day when I wore the headscarf to department again, a fellow woman doctor said, ‘What’s the point of wearing a scarf now. We have all seen you without it anyway, so you can stop the act.’

In many hospital departments, women are segregated according to dress because of this scrutiny. They faced extra pressure to fit in with group norms, but at the same time, their differences were exaggerated by stereotypes so that boundaries between various identity groups were further cemented (Kanter 1977). Those women doctors who covered their head or wore a veil often sat separately in their duty rooms, meetings and in the cafeteria from women who did not wear *dupatta* or favored more Western styles of clothing. I also realized over time that each clique had internal discourses about the suspect morality and religiosity of the other. Those who wore the veil are sometimes derisively called a “ninja”, and their behavior is referred to as “too strict” or “too conservative” for workplaces. Similarly, those who did not veil were constantly berated for being too sexual, breaking with Islamic teachings and “Eastern traditions”, or being inappropriately dressed for workplace. Hadia, a medical officer in the Pathology department (who wears a *dupatta* that covers her head), for example, said about her fellow colleagues:

I think most hospitals have really good working environment, and people respect each other. But people can destroy this environment (*mahol*). Some women in my department wear sleeveless clothes, or do not wear

head scarf (*dupatta*). Some of them go out with our *male* colleagues, and they talk in a *friendly* manner. That is not the way to behave in a place like hospital. They cannot complain if people gossip about them.

On the other hand, in the same department Dr. Sameen (who wears a lab coat, but no *dupatta*) has this to say, “I do not like how *conservatively* people behave in this department. They tell you to wear a *dupatta*, cover your head, do not talk to this or that. If you talk to a *male co-worker* gossiping starts. People have to grow up really. We are all co-workers here.” Thus, practices of *purdah* not only affected how men and women interacted with each other, they also affected the relationships between women. The scrutiny and constant surveillance of their dress and behavior that women face creates a hostile and unwelcoming workplace for them.

### **Limits of Bodies: The Modest Comportment**

Apart from dressing practices, *purdah* also involves a certain comportment of the body. Pakistani women and men are careful at all times to not touch anyone of the opposite gender, and maintain a respectful distance, even in crowded places. The rationale of this practice is derived from the practice of the Prophet Muhammad, who refused to touch or shake hands with non-kin women during the administration of an oath. This is further reinforced by conceptions of purity (in certain Muslim schools of jurisprudence) which consider touching a woman impure and defiling, requiring one to repeat the purity rituals of *wudu* after touching a woman, even when it is unintentional and asexual. They are also expected to keep their eyes downcast, and not to look at anyone of the opposite gender directly (a practice mandated by Quran and commonly referred to as *ghuss-e-basar*, literally control of the gaze). Young girls are generally told

by their families not to laugh or talk loudly, since, as my participants frequently mentioned, “The voice is also to be veiled (*awaz ka bhi purdah hota hay!*)”

I was most conscious of this during rounds at the hospital and in operation theaters. These were the times when most practical skills were demonstrated, and students and junior doctors alike squeezed themselves to be as near to the patient’s bed as possible to get a better look. But even here, everyone was extremely careful not to touch anyone of the opposite gender, though given the tight space, it took some careful maneuvering. On a couple of occasions where someone got too close, they were quickly and gruffly rebuked and told to stand aside.

Interestingly enough, *purdah* is not just limited to the bodies of the women, it is related to everything that is even remotely feminine and/or sexual, which is then excluded from public masculine space. Women until recently could refuse to have their picture on identity documents (ID card, passport etc.), and this policy was changed only after increased security and surveillance in aftermath of 9/11. Even the names of women are part of *purdah*: in more conservative areas of Pakistan, it is not uncommon to address letters as “*Andaroon-e-khana* (to the inside of home)” if they are meant for a woman. Any display of affection between husband and wife, like holding hands, is frowned upon even inside the homes, if it is in the presence of others. When the government decided to promote contraceptives on television, they had to make advertisements that had no mention of sex or contraception to appease religious scholars. One of the earliest ads for condoms had no text or spoken words, and the viewer was supposed to figure out the purpose of the advertisement. Gynecology and obstetrical departments in the hospital are especially remarkable in this regard as they become more or less women-only spaces.

Even though doctors are of both genders, no men (other than doctors) are allowed inside the premises during any appointments or in labor rooms. Expectant fathers stay outside, waiting for their names to be called to get a glimpse of their child. *Purdah* thus becomes a physical and symbolic barrier that keeps masculine and feminine bodies in separate worlds.

### **Speaking Modestly: *Purdah* as Gendered Language**

The conversation between men and women are also affected by the norms of *purdah*. The justification of this practice also comes from Quranic statutes of *purdah*, which ask women to speak to men from behind a curtain, and be strict in their demeanor while talking to men. This is not unique to Pakistan, since men and women are excluded from each other's conversations even in Western countries (for example, women are generally excluded when men talk about sports and men are excluded when women talk about pedicures). Patterns of everyday interactions within organizational settings also produce enduring structures of dominance and submission. The conversation patterns of men and women have been extensively analyzed to show that they differ markedly in terms of initiating new topics, taking turns, and the emotional meanings that they attach to utterances and silences (Zimmerman and West 1996). Hence, women often do the interactional work of involving others in the conversation, and negotiating and understanding, while men seek to reaffirm status, give advice and assert their independence (Fishman 1997; Tannen 2001).

However, because of the norms of gender segregation in Pakistani society, men and women develop a different vocabulary (almost a different language) for bonding and socialization. The Urdu dictionary is filled with references to women's language, or

*begamati zuban*, spoken in women-only enclosures (*zenanas*) of homes (Minault 1984). In modern urban homes, these separate enclosures have disappeared, and so has the unique language of women. But the colloquial language of men still persists. Filled with sexual references, explicit puns, double entendres and florid *galian* (abusive words), it is a part of masculine friendship from which women are essentially excluded.

Since men and women are generally socialized by their families in childhood to keep friendship networks within their own genders, and informal cross-gender relationships particularly in workplaces are considered sexual and immoral, men and women doctors develop a deep seated habitus of mutual avoidance. Women, because of their socialization, internalized the norms of *purdah*, but the demands of the workplace forced them to work against their habitus. Because of this norm of avoidance, both women and men struggle to acquire a “gender neutral” vocabulary to meet the demands of a modern workplace where they have to contend with each other’s presence. An example of this is the way men and women address each other in workplaces. Both men and women doctors had different ways of addressing their same-sex peers depending on the depth of their prior relationship (using first name, or more colloquially *yaar*, *jigar*, *lallay* literally friend). But in cross-gender conversations, both men and women struggle to address each other in a way that is respectful. In hospital departments that have a majority of men, like surgery for example, when conversations became more informal over tea, a senior man doctor simply asked women to leave, “Girls, now leave, we have our own stuff to talk about (*kurio hun tusi jao asan apnian gullan kurnian nay*).” While he might have used the word “girls” in an affectionate, fatherly way, it nevertheless creates an image of women as immature beings and subordinate workers. Senior women

doctors similarly enacted a motherly identity when addressing their juniors, calling them son (*beta*) or child (*bachay*).

Furthermore, these informal relations of work extend far beyond workspaces. In fact, socialization outside the work environment and “networking” is often a significant component of work relations. *Purdah* related considerations are important here as well. When “ward parties” and get-togethers are arranged, women are often not allowed by their families to participate if they are alone or if the event continues late into the night. More commonly, men and women prefer gender segregated events, where they can socialize freely. Both men and women expressed similar sentiments in this regard, as Dr. Javaria, a young medical officer, explained, “We are just not *comfortable* enough in *mixed company*. We cannot talk *freely*. I think it is our *training*, things that have been *drilled* in our minds since our childhood. If it’s even a *mixed gathering*, after a while, men and women are huddled in opposite corners and everyone is *uncomfortable*. So why not have separate events.”

On one occasion, some doctors were invited with their families to a colleague’s home. As is customary in most Pakistani homes, men and women were seated separately. But one of the doctors was a woman, and she did not know any one of the other doctors’ wives, none of whom was a doctor. It created quite a conundrum for her to choose where to sit. In the end, she decided to join the group of her men colleagues. But her action was ostracized severely by both men and women present, since it broke the customs of the host’s home and was considered rude and transgressive of modesty.

## Purdah Experienced

Given how far reaching and omni-present the system of *purdah* is, it is not difficult to imagine how it not only affects the social interactions between doctors as an individual practice, but also dictates the organization of space and allocation of work within the hospital through its institutionalized forms. Moreover, persons (both men and women) who practice different forms of *purdah*, and hence have different personal rules for interacting with other genders, experience workplaces in fundamentally different ways. While I have discussed the general findings of my fieldwork (as they relate to the themes of *purdah* and workplace), in this section I specifically focus on a few narratives of my research participants to highlight the heterogeneity of experiences that result from different practices of *purdah*. I have selected the narratives of Raheela, Rubaba and Rifa because even though they worked in the same department, they had remarkably different experiences in their workplace.

Raheela, a senior doctor in the ward, wears a veil, from which only her expressive eyes are visible. She combines it with a traditional *abaya* and a white lab coat or a brilliant green surgical kit when she is operating. She started wearing a veil when she was admitted to a co-educational medical college, and considers it part of her devotion to her faith as a Muslim woman. She found it quite empowering during her education, as she explained, “I began to realize that women’s dress and her appearance greatly influence other people's reaction towards her. Veil allows people to look beyond the superficial appearances to focus on my character, my ideas, and my skill. Now I did not need to focus on my appearance, my dress, my makeup, to qualify as attractive and successful.”

While her roommates in the hostel spent hours in the morning putting on make-up, she could just put on a veil and rush to the class. She generally avoided the company of her men class fellows, but since her class had a majority of women students, she was never short of friends. Her choice of surgery as a specialty is also fascinating in this regard. “We are all same in operating theater,” she points out. “Everyone wears a veil and covers their face, it is only the skill in your hand that makes a difference.”

But in a surgical unit, surgical skill is only one of the things that makes a difference. There is a strong atmosphere of camaraderie and being part of a family among doctors in the unit. Although the formal organizational structure dictates that there are certain relations of deference and authority, more informal relationships dominate the way doctors in the ward relate to each other. Once the round breaks up, students congregate around a senior resident, who is known for his teaching style or skill. Informal classes and tutorials happen throughout the day, and even the doctors from other wards visit if there is news of an interesting case (and such news spreads fast). New research projects are discussed over food or during a fierce post-op game of basketball. Like a close knit group, the surgical ward has its own established rites of initiation and bonding rituals which form the basis of group solidarity. Perhaps the most important organizational aspect (especially for learning and skill building) is how surgeries are allocated to various doctors. It is common for an intern to beg senior residents for a “solo surgery” or to assist on a difficult and uncommon procedure. Seniors in return demand a huge party at a place of their choice. This results in playful banter and haggling where junior doctors bemoan their empty wallets and low pay and are in turn teased about getting off cheap by offering chips and coke for a big surgery. First pay, start of private



practice, promotions etc. are similarly celebrated with parties or going to a favorite café with friends, becoming part of bonding rituals.

Women doctors in general and those who practice more traditional forms of *pardah* especially, like Raheela, face an obvious disadvantage here. They cannot participate in the group banter, engage in playful fights for surgeries or go off to parties with their colleagues. As I mentioned in Chapter 4, women's mobility, especially with non-kin men and at night, is tightly controlled by their families. Moreover, as I discuss above, transgressing the gender boundaries of *pardah* is seen as immoral and dishonoring. If a woman doctor is friendly with her colleagues, it can sometimes cast aspersions on her character. As a result, women are not considered "part of the club". Raheela told me, "During my shift in emergency ward, I would sit with nurses, as there was no separate duty room for women, and on the duty station all men doctors just sat together talking to each other. When a new case came in, they did not call me, saying that if she does not sit with us, we are not going to ask her to come and do surgeries." During the ward week (a shift during which residents spend a whole week living in ward), her colleagues would order food and share it, with lively conversation. Because of her veil, she could not join them, since for eating the food she would have to lift her veil. She either ate alone, or with her friend who was similarly veiled. Her colleagues (erroneously, I might add) perceived her as being haughty, aloof or uninterested. They refused to do duties with her. "I think I was wrong then", she reminisced about her training. "I thought that my skill should speak for itself, and since I am good – and I was good – I will get surgeries. I don't need to talk to anyone. But it does not happen that way." Other women doctors who wear the veil have to be creative to be part of the group without forgoing

their *purdah*. They sit and talk with men doctors and share drinks (which they can sip through a straw under their veil) but eat separately (for which they have to lift the veil). Although women like Raheela do their job – and do it well – because they are excluded from informal interactions and social networks, their training as a doctor suffers. Raheela spent the first two years of her training assisting surgeries or handling minor traumas, while her men colleagues did laparotomies and handled major traumas. “I don’t mind it now, because of that time I became very good in my basic surgical skills. But I was slow and deliberate, I wanted to be sure before just hacking away, as anyone would, who does not get a lot of practice. So my colleagues labelled me a “slow surgeon.” They wouldn’t let me operate in emergencies, telling me that ‘slow surgeons have no place in emergencies’, but they didn’t let me practice either. I did not handle a lot of major surgeries in emergency and that’s where surgical skill is really polished.”

Rubab, the women doctor I introduced in the beginning of this chapter, works in the same ward. Her *dupatta* is tied in an elegant knot under her white lab coat. She does not wear a veil but believes in maintaining only formal relationships with her colleagues. She does not socialize freely with her co-workers who are men, refusing to participate in their jokes and banter and keeping conversations strictly related to work. She partially overcame this exclusion faced by women only because she joined the unit with glowing recommendations from a very senior man surgeon, and thus was favored by her advisor (a man) who was also the head of department. Still, she had to deal with what she calls “*male politics and back biting*” as she was excluded from opportunities of training and research. Her colleagues visited bosses at work and afterwards for socializing, to “suck up” to them, and to tell them how heroic they were at a surgery today, while she was left

to pick up the brunt of “grunt work”, putting in notes, completing patients’ charts, monitoring their output etc. Similarly, in emergency, the most hectic part of their duties, while she did patients’ examinations, took histories, put in stitches for lacerations and cuts, her colleagues sat with senior doctors enjoying tea and snacks. But when a major surgery was performed, and senior doctors were operating, they asked their men colleagues to assist, and not her. After two years of feeling unsure and isolated, she finally managed to talk to her advisor about it, and he responded surprisingly by making her registrar of the ward, “You cannot deal with men from a subordinate position, you have to talk to them from the top.” Being a registrar made her in charge of assigning duties and distributing surgical cases to other doctors. It was also a vote of confidence in her by her advisor, since being a registrar is probably the most important management post in the working of a department in Pakistan. It helped her a little, since her previously aloof colleagues had to be deferential to her now. Still, since her men colleagues spent a lot of time socializing with their seniors both at work and afterwards, they were invited to join private practices and participate in research opportunities. Being the only woman in a ward where everyone else was a man, and the constant stress of dealing with the pressure of her men colleagues she felt completely isolated and stressed. During her training, she frequently cried at work and spent many sleepless nights at home. Dr. Rubab and Dr. Raheela’s experiences are quite reminiscent of Patricia Yancey Martin’s (2003, 357) observation, “Men were the bosses; men were predominant; men were in control and had the power to define situations as they saw fit. Certain forms of masculinities and a form of cultural masculinism were hegemonic. Women felt nervous even about claiming that men behaved like men because men believe (and say) they behave like workers.”

Rifa, a junior doctor who joined the surgical unit sometime after Raheela and Rubab, wears a simple headscarf that covers her hair but not her face. She has seen the exclusion that her predecessors faced in the ward and so she decided to try a different approach:

I saw what happened to Dr. Rubab and Raheela. Both of them were really good in their work, but other surgeons in the ward did not have a good opinion of them. They were considered strict and isolated. Because of these perceptions they had a lot of problems with their training. And since they did not talk to anyone, nobody knew their perspective. I think it was a communication gap between them and other people in the unit.

Instead of receding from conversations of her men colleagues, she actively participated in them. To be a part of masculine networks of interaction, she acted like men. Just like her men colleagues, she argued with her peers and seniors over parties and surgeries. “I fought with them for surgeries. When a new patient rolled in, I was there in the middle of the hustle, calling dibs on the surgery. If one of our poor colleagues did a new procedure, we destroyed him, we nearly bankrupted him.” Instead of gender segregated events that were previously the norm, she arranged excursions and outdoor trips for the whole ward, and insisted that both senior and junior doctors (men and women) participate. If her men colleagues were going out to party late at night, she insisted on accompanying them. If they ate at a roadside hotel (*dhaba*), she ate with them. “You know how people here think, like, one girl alone with six, seven boys. People talked, but I never cared. Sometimes at night, boys would say, you are the only girl in emergency, you can leave and go home. But I never even considered it, how could I leave my duty?” Her attitude earned her the fitting nickname of “guerilla (rebel)” and in time she succeeded Dr. Rubab as registrar, one of the only two women ever to be a registrar in

the whole history of that surgical unit. Eventually, her attitude made it easier for her junior women doctors to follow her example and actively participate in friendly conversations with their men colleagues. As she explained, “It changed the environment of the ward a bit. People realized that they can relate to each other as co-workers, and that it is okay to have fun after you have done a stressful job.” Her (quite successful) renegotiation of the gendered boundaries in organizational interactions shows that it is possible to challenge the gendered borders in workplace. It also indicates that women, in order to be successful, had to conform to masculine norms of interactions.

The heterogeneity in experiences of women doctors and multifaceted bodily, spatial and linguistic aspects of *purdah* that I discuss above show that sartorial forms of *purdah* often played a smaller role in how men and women related to each other. Instead, feminine work experiences were determined more by the norms of interaction dictated by the state, family and religion and negotiated by individuals, which became the organizing principle in social life.

### **Negotiating Difference in Workplace**

The norms of *purdah* and its related restrictions on mobility and interaction across genders have profound implications for Pakistani women’s participation and persistence in modern occupations. Although many state and institutional policies favor gender segregation in workplaces as I discuss above, with a greater number of highly educated and professional women, their presence is increasing in workplaces. Hence, both men and women have to contend with conflicting demands of social norms and workplace ethics. While the structure of their jobs and professional excellence demands that they form extensive networks among their colleagues and cultivate relationships that go beyond

formal relationships, the norms of cross-gender interactions in Pakistani society dictate that relations between men and women (other than what are determined by formal structure of family and kinship) are always defined by avoidance and segregation. Managing these contradictory structures created a stressful environment, where women either face exclusion and isolation or they had to adapt their behavior to match the demands of their work, sometimes even against their personal beliefs and socialization. Moreover, since *purdah* of women is tied closely to the notion of honor (Papanek 1973), the penalty for women breaking the norms of interaction is much greater than it is for men, as it is seen as immoral, dishonoring, unfeminine and transgressive of Islamic modesty. Thus, these individual and institutional practices keep men and women in their separate worlds, even when they work side by side.

While there is considerable research that shows women who wore hijab faced ethnic and religious discrimination during hiring and employment practices in Western contexts (Ghumman and Ryan 2013; Syed and Pio 2010; Ghumman and Jackson 2010; 2008), the experiences of Pakistani women doctors indicate a different form of bias resulting from the intersection of gender with religious authenticity and morality. Unlike men, who can just *be* in the workplace, women in Pakistani workplaces are expected to either remain invisible or act “like men” (and interact with men as men do) like Rifa, in work settings. Engaging in “*purdah*” (either in its sartorial form, or as an ethic of interaction or both) is perceived as way of practicing gender that is unacceptable to the hegemonic masculine norms of interaction in workplace (Martin 2003). While individual practices and actions, like Rifa’s conscious decision to participate in social activities, improved experience of workplace for some, and therefore may be interpreted as a form

of agency, it is hardly empowering for women on the collective level. Acting “like men” actually legitimizes the gendered structure of work, since it does not problematize the gendered nature of workplace relations or challenge the inequitable distribution of learning resources based on gender and not individual performance.

Moreover existing research on hijab does not conceptualize *purdah* as it is institutionalized through governing apparatuses like the family and the state (like gender segregated hospitals and educational institutions in Pakistan). Even though individual actions of the women doctors may be interpreted as self-reflexive, subversive and assertive, the institutions and social structure in which they are embedded and the spatial architecture in which they move continue to influence and dictate their experience (Catlaw 2007). Hence in many cases it may not matter what a woman doctor’s individual beliefs are, or what meaning she individually ascribes to her practice of *purdah*, the institutional segregation created by material structures of the workplace and maintained by gendered norms in workplace continue to dictate her behavior.

Finally, various codes and ethics of conduct of *purdah*, including its sartorial forms (of which the veil is an example) are part of cultural discourses, and thus are sites of contestation, negotiations and re-construction. The meaning of these norms is not fixed, but rather produced through individual practices and interactions between social agents. However, various “readings” of the specifics of *purdah* (especially the veil) concentrate only on how this practice is re-appropriated or performed by Muslim women to assert their identity, as intentional meaning-making acts and as a way of re-interpreting religious discourses from which their voice was previously excluded (Brenner 1994; Read and Bartkowski 2000; Ahmed 2014). While asserting the position of Muslim woman

as active, intending subjects, these scholars do not account for the response and presence of other social agents (men and women) as they react to symbols of *pardah* or enact *pardah* related norms. It is important to contextualize the individual empowerment, agency and self-identity that is asserted by various forms of the practice of *pardah* within collective empowerment by women doctors.

The social context imbues individual “doings and sayings” with meaning in a dialogical process, just as an audience understands, gives meaning and reacts to a performance. Doing *pardah* is an example of such a performance. Women doctors invariably articulate their practice of *pardah* in terms of asserting their identity as modern, educated Muslim women, and thus perform *pardah* for their individual empowerment. However, this performance is interpreted by their audience (their co-workers) in different terms: Their lived experiences in the context of Pakistani society show how these practices were understood as part of “doing gender” in workplace interactions which reinforced gendered hierarchies in the organizational structure.



## CHAPTER 7

### IN THE COMPANY OF UN-EQUALS: PATTERNS OF SPECIALTY CHOICE BY WOMEN DOCTORS

In the 1970s, the number of women in medical colleges across the world began to increase, as a result of feminist movements and anti-discrimination laws. By the 2000's, nearly 40% of all graduates of medical colleges in the United States (Bickel et al. 2002; Bickel 2001) and approximately 50% in the medical colleges of the United Kingdom were women. In Pakistan, the quota that fixed the number of women in medical colleges at 20% was lifted in 1990, and the number of women in medical colleges has continued to increase ever since (PM&DC 2016). Now more than a hundred years later, women medical students and doctors have come a long way. There are more women than men in the medical profession, not just in Pakistan but in many countries across the world (Levinson and Lurie 2004; Philips and Austin 2009). Women no longer face overt gender discrimination in the form of rejected applications, they have vocal and active professional organizations, and are legally allowed to participate in all specialties, and to head medical services, organizations, and laboratories (Lorber 1993).

But despite this rising tide of women in medicine to almost parity with men as the numbers would suggest, there is still a “glass ceiling” in the medical profession when women physicians try to achieve career mobility, or aspire for visible, top tier positions of authority and status (Lorber 1993; Riska and Wegar 1993; Riska 2001; Bickel et al. 2002; Reed and Buddeberg-Fischer 2001). As data from the United States, the United Kingdom, and Nordic countries suggests, more men than women are likely to continue post graduate education and specialize in various medical subfields after graduation

(Gjerberg 2001; Nonnemaker 2000; Allen 2005; Dorsey, Jarjoura and Rutecki 2005). Moreover, although in most Western countries the number of women opting for specialization is increasing, distinctly different patterns in specialty choices still persist. A disproportionately large number of women prefer to specialize in gynecology/obstetrics, pediatrics, pathology, internal medicine and psychiatry (Dorsey, Jarjoura and Rutecki 2005; Lambert and Holmboe 2005). Similarly, although the number of women joining surgical specialties is increasing, the number of women in surgery and allied fields remains disproportionately small as compared to other disciplines (Baxter, Cohen and McLoed 1996; Barshes et al. 2004). In Pakistan, similar patterns exist in the specialty choices of women. Even though the gap between men and women specialists is decreasing every year, fewer women than men chose to continue their education beyond the basic medical qualification. Moreover, over the years women have tended to choose only a few specialties, like gynecology and obstetrics, pathology, radiology, psychiatry and pediatrics, and women doctors have been conspicuously absent from the discipline of surgery.

The consequences of this gendered division are manifold. Continued education and training in the form of specialization is not only a precursor to positions of higher rank, it also leads to increase pay and status. As women tend to specialize less, they are under-represented in the upper echelons of the medical field and earn less than men doctors (see Appendix A for these trends). As Riska and Wegar (1993) point out, there are indications of women clustering in certain specialties (especially family medicine) where they are more likely to be found stuck in fixed pay positions in the public health sector – a process which they call ghettoization. On the other hand, with the increasing

industrialization of medicine, health professionals are already becoming stratified between professional elites (usually specialists) and ordinary practitioner work forces (without specialization), with women being excluded from the elite ranks (Relman 2007; 1991; 1980). More importantly, these differences in career structure are an indication that rather than a complete integration of men and women doctors in the medical profession, gender lines have been merely redrawn, and the gendered processes that result in these persistent differences are still operating.

These differences in specialty selection also have an impact on the provision of health services. As the number of women increases in medical graduates and most of them tend to cluster in only a few specialties, there is a shortage of physicians in other disciplines. Particularly in surgical specialties, there is a mismatch in the supply and demand of physicians. In the case of Pakistan, simultaneous trends of an increasing number of women in younger cohorts of medical graduates (who are more likely to remain restricted to a few “women friendly” specialties) and the attrition of men doctors from the Pakistani health force through emigration have resulted in a shortage of doctors, particularly in general surgery and allied specialties (Mumtaz et al. 2003; Talati and Pappas 2006).

In this chapter my focus is on the specialty choices of Pakistani women doctors. Why some specialties are considered feminine while others are not? What makes some medical subfields more attractive to women doctors? More importantly, what are the consequences of this gendering of specialties for Pakistan? To answer these questions, first I briefly review research on the specialty choices of men and women doctors. Then I discuss two different aspects of specialty choice for women doctors in Pakistan. First is

the importance of a controllable lifestyle and the expectation of work-life conflict, which explains why women doctors tend to choose specialties that have a more predictable work schedule. Second is the gendered nature of medical work, where the discipline of gynecology and obstetrics is considered particularly suitable for women. I also discuss how increase of women in gynecology and obstetrics is related to the status and prestige of this field. Finally, I discuss the impact of these differential choices for the health delivery system in Pakistan.

### **Gender Matters: Choosing a Medical Specialty**

Why do women choose different specialties than men? This question of specialty choice has been an active focus of research in academic medicine; and gender, more than any other factor, is correlated to differences in specialty choice (Bowman and Gross 1986). One of the important reasons behind the occupational segregation between men and women, particularly in the case of medical specialties, is the difficulty in combining domestic responsibilities with the requirements of labor force participation. There are a number of perspectives which explain the complex interdependence of familial and organizational structures, individual preferences, and work. Individual perspectives describe women's differential choice of medical specialty either in terms of their social and emotional values based on gender role socialization or in terms of economical rationality as women have different priorities regarding their work and domestic responsibility. Various occupational choice models based on human capital theory hence describe women's differential specialty choice in terms of their rational decisions regarding how they want to combine their work and family commitments, and how important pay is for their lifestyle (Becker 1985; Chafetz and Hagan 1991; Hakim 1998;

2000; and a counter point to preference theory in Crompton and Harris 1998a). In contrast, structural perspectives describe the segregation of women in different occupations in terms of the structural context of gender and work. In the case of medical specialties, the structure of medical work, the organization of post-graduate education and male exclusionary practices in various specialties are considered especially important (Riska and Wegar 1993; Gjerberg 2003; 2002).

Apart from gendered socialization and personal preferences, perhaps the most important factor that affects women doctors' choice is the expectation of work-life conflict (Dorsey, Jarjoura and Rutecki 2005; Van der Horst et al. 2010). Different medical specialties have very different training schedules and time requirements and hence offer different opportunities to combine work with family (Crompton and Harris 1998b). Indeed difficulty in managing domestic duties with medical training can not only be a deterrent for women wishing to join them, but is also a leading cause of burn out of women physicians and their eventual attrition from work force (Keeton et al. 2007; Langballe et al 2011; Rizvi et al 2012). The expectation of controllable work hours and life style is one of the most frequently cited reasons behind choosing a particular specialty (Dorsey, Jarjoura and Rutecki 2003; Newton, Greyson and Thompson 2005). In Pakistan, the expectation of work-life conflict is an especially important factor in women's career decisions because of restrictions on their mobility (discussed in Chapter 3), expectations to participate in the care of multiple families in a joint family system, as well as the unavailability of public child care and the gendered division of household labor (Aslam et al. 2011). As a result, the under-representation and lower career mobility of women doctors is not just because of individual characteristics or

institutional/organizational constraints. Broader patriarchal family structures outside the medical profession also play an important role in limiting career success.

To better understand the relationship of specialty choice with the work-life conflict, I analyze the tradeoffs between career and family along two dimensions: The long term work-life conflict, which accounts for the expectation of training and work structure over the course of whole career; and short term work-life conflict, which is indicative of day to day problems of balancing work demands with family and domestic responsibilities.

### **Assuming an “Ideal” Worker: Long term Work-life Conflict**

This aspect is related to the expectation of possible conflicts between the long term structure of a career and significant events in the life course of the worker (in this case, a doctor). For example, more prestigious (and better paying) specialization pathways in the medical profession begin immediately after graduation, and generally requires 4 or more years of intense training and further study. In Pakistan, for example, the Fellowships offered in various specialties by The College of Physicians and Surgeons of Pakistan (CPSP) are considered the most prestigious. This training ideally begins immediately after medical graduation (that includes one year of a house job) after a preliminary examination (FCPS -1, part one as students call it) is passed. The training itself requires 4 or more years with many specialties requiring an intensive midway examination (intermediate module), and another examination at the end of the training (FCPS – II, or part two). There is no option to “freeze” the training or put it on hold, if other life events (like the birth of a child, illness, death of a loved one) intervene. The specialization pathways assume an ideal biography of a doctor with fixed time for certain

status passage events, which often does not match with the expected life course of most women. In Pakistan, for example, the timing of specialist training coincides with the time when most women are expected to get married and start a family. Hence, women in expectation of possible conflict with the specialization pathway and their family formation may choose to not specialize at all, forgoing the increase in status, pay and occupational opportunities that come with specialization. Those who do specialize may choose less time intensive specialties, or those pathways that require less time for training (and hence are considered less prestigious and tend to be low paying). Dr. Samina, a 29 year old doctor, for example chose to specialize in hospital management rather than choosing a clinical specialty.<sup>40</sup> She explained:

The clinical specialties or fellowship would have needed four years of training, may be more. I do not think that I can combine training with having children. So I opted for a masters instead. It has only four semesters, and I can complete it in two years. Besides the required course work is only for the first year and that is the most intense part. After that I just have to write a thesis. So if have a baby by then, it will not be difficult to do both things.

Her response indicates how women visualized their career in terms of conflicting responsibilities and made choices that enabled them to combine work and career in the best possible way. Chafetz and Hagan (1996) similarly suggest that women in professional work have to contend with two conflicting sets of norms: one is their

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<sup>40</sup> Medical specialties are broadly divided in two groups based on the direct involvement of practitioner in the patient care. Non-clinical specialties are those where doctors are not involved in direct patient care. These include basic sciences (anatomy, physiology, biochemistry, pharmacology, etc.) and management specialties (like public health, hospital management, etc.). Clinical (or practicing) specialties are those where doctors are involved directly in patient care. These include diagnostic specialties (pathology, radiology and their subfields), medicine, surgery and their allied fields.

familial responsibilities and the other is individual success and fulfillment. In order to reach a compromise, most married women increasingly “satisfice”, that is, attempt to reach a reasonable level of satisfaction and success in both career and family, rather than sacrificing one for the other. Shaheena, a 37 year old woman doctor who has her own private practice as a gynecologist for example explained:

I was already running my own clinic when I decided to specialize. I had a large family by then, three children and an aged mother-in-law of whom I had to take care. If I had started a long training like a fellowship, I would never have been able to complete it. Even though in ideal world I would have liked to do a fellowship, I decided to do a six months diploma in gynecology.

In Pakistan, the long term work-life conflict is exacerbated by the fact that, since arranged marriage is the most common and most socially acceptable form of marriage, many women have no idea while planning for their career what kind of work-family conflicts they will face when they are married. In fact, they also have no idea whether their spouse will go along with their career paths at all. Shaheena, 35 year old medical graduate, for example, has a gold medal in medicine and, encouraged by her peers and her professor, she planned to specialize in internal medicine. Before she could join the specialization program, however, her family found a really good match for her husband, and she was engaged to be married. Her husband lived and worked in a small town in Saudi Arabia, forcing her to move to that country. Though he encouraged her to pursue her studies in Saudi Arabia, there was no specialization program in that town which admitted foreigners, nor was she eligible for any job in the country because of her lack of experience. Similarly, Raheela, a 40 year old pediatrician, was married immediately after she completed her specialization. Her husband, also a doctor, told her on her wedding



night that he did not want his wife to work. Instead of creating difficulties in her marriage and dishonoring her family, she acquiesced and had not practiced since. Samina, another women doctor, was in the second year of her residency in psychiatry when I interviewed her. She told me that she was recently engaged to be married and her fiancé had already told her that she will not be working after their marriage. She explained that her family did not marry outside their specific caste, and they had found a good match with great difficulty. So the fact that she will have to forgo her career after marriage did not matter, her parents' duty to marry their daughter took precedence.

The timing of marriage and education decision-making, and the fact that most women have little choice in their spouses, creates a profound uncertainty and unpredictability for women and their families (who are in turn reluctant to invest in women's future because of this ambiguity). The frustration and anger that results from this ambiguity is best illustrated by the following anecdote. One day, during a small meeting with a few doctors and their families, a fourth year medical student, Sania, asked my advice about doing internships in US and preparing for a licensing examination in the United States. I offered to put her in touch with a couple of my friends who are working in the United States as doctors. Another doctor, Abiha, married with a couple of kids and specializing in Pathology, interjected during our conversation. She told Sania that it is premature for her to make such plans. If her parents found a good match for her in Pakistan, or if her husband does not like her to work, it will be heartbreaking for her. Sania's mother also joined in, saying that this is exactly what she keeps telling her daughter. A good, happy marriage, after all, takes precedence over career and work. "It is selfish of girls nowadays to think only about their career and not about their parents and

their grey hair, who need to fulfill their duty and marry off their daughters (*farz ada karnay hain*),” she exclaimed. Both Sania and Abiha were visibly unhappy about this, and Abiha bitterly replied, “We know auntie, what parents have to do. I think it was better when they buried the girls alive after they were born, or married them in childhood. At least then girls knew how to tailor their expectations.”

### **“Time-Bind”: Short Term Work-Life Conflict**

This aspect of the work-life conflict explains the expectation of day to day conflicts between career and family responsibilities. Different medical specialties have a different job structure and time demands, and women doctors take this into account when they are choosing their specialties. Diagnostic specialties (like radiology, pathology) in Pakistan, for example, have a shorter work-week and a more predictable routine of work shifts. Most doctors that work in these specialties have a fixed 8 am to 2 pm work day, and have very few 24 hour or emergency duties. Similarly, women doctors who opt for academic medicine, that is, teaching in medical institutions, have a predictable and shorter work week. This predictable work schedule makes it relatively easy to combine domestic and career responsibilities. It is not a surprise that in Pakistan these specialties have seen an influx of women doctors, and that many units in these disciplines now have a majority of women doctors.

A paradoxical trend in this regard is the increasing number of women in academic medicine, particularly in basic sciences (anatomy, physiology, bio-chemistry, pathology and pharmacology) in Pakistan. Across the world, women are generally under-represented in academic medicine, which is considered the most prestigious and well paid area of work in medical profession. As I mentioned above, the job structure and

predictable life style of academic medicine plays an important role in the increasing influx of women doctors in the teaching aspect of the medical profession. More importantly, unlike most western medical institutions, where academic medicine is research oriented, and hiring and promotion is strongly linked to research productivity, in Pakistan teaching in medicine has a routine job like structure, where promotion is simply based on years in service. This makes teaching in medicine a very attractive pathway for women. Dr. Farrukh, who has been teaching anatomy in a large public hospital, explained, “My job starts here at 8 am, and usually I have one or two classes to teach daily, plus a couple of small tutorials. I am free by 2 pm. I think teaching is the best possible way to have to combine a job and a family in medicine.”

On the other hand, post-graduation training in the general surgery profession creates the greatest work-life conflict for women, since it takes 5 years and is considered one of the most intense training programs. Surgical trainees work every day from 6 am to 2 pm, but these timings are extremely unpredictable. If a patient is being operated on, a surgeon cannot just wash their hands and leave, and major operations can sometimes take more than 12 hours. It means that most surgeons actually work past their shift timings on most days. Surgical residents also have to work weekends and holidays, and perform duties in the emergency ward (sometimes for more than 36 hours straight) and in the outpatient department. During the first two years, surgical residents also do “ward weeks”, where they live in the ward for a whole week, eating and sleeping in the duty room, to look after patients 24 hours a day and to perform post-operation and pre-operation care. Apart from these regular duties, trainees are expected to participate in

research, be part of committees, organize classes and participate in teaching students and doctors.

Needless to say, this training is difficult for *any* human being to manage without an extensive support system, but for women with small babies, or those who also have the responsibility of running a home, keeping up with this time table is nothing short of impossible. Indeed, all the women surgeons whom I interviewed deferred their marriage and parenthood until after the completion of their training or did not marry at all. In a society where marriage is almost universal, and its timing for women is almost always beyond their control, to be able to prioritize one's career is highly unusual. The women who joined these specialties were almost always marked by an amazing personal will, and backed by exceptionally supportive families and husbands. Faria was a second year post-graduate trainee in surgery when she was engaged to be married. The only request that she made of her parents when they were screening for possible matches for her was that she be allowed to work after her marriage. For good measure, she had this clause added to her marriage contract. This is exceptional since adding such clauses to a standard marriage contract (i.e., *nikah nama*) is almost never done and considered a social taboo. Her husband, whom I also interviewed, unequivocally believed that his wife should work if she wished. Like any other Pakistani couple, both of them were under pressure from their respective families to produce children immediately after marriage, but Shaheena still had two years of training left. Although her duties were relatively easier, they decided to delay having a child until after her training was finished. It was her husband who fielded all the questions about when they were going to have a baby, taking the blame for deferring parenthood. Hiba, another woman surgeon, had two

children when she started her training. However, her sister-in-law moved in with their family and assumed the complete responsibility of child care and domestic work while she completed her training. Fazeela, who is a professor in surgery in a public hospital, similarly recounted how her mother-in-law and her sister took turns to take care of her children while she worked or prepared for examinations.

However, these women are the success stories, and for each one of them, there are many other women doctors whose families simply refused to put up with the work hours, and who had to give up their work altogether, or change their specialty. Dr. Hooria, a 38 year old woman doctor, started a specialization course in oncology in a large private hospital after her children were already school age. She expected that it would be easier for her to return to her career at this time. The difficult work timings, however, were a huge deterrent, as she described:

My work shift timings were 8 am to 5 pm every day, six days a week. And I had a 24 hours shift once a week. My children were going to school at that time but it was still very difficult to manage. My husband had his own career and he could not help. I had to leave my children with my mother, but that arrangement was not working. Their grades at schools were falling as I did not have time to help with their homework. If they fell sick or my mother could not keep them, the whole system fell apart.

Eventually, due to this constant difficulty she decided to permanently quit her job, and the experience was so traumatic for her and her family that she decided not to continue her career at all. Dr. Lamia, who started a specialization degree in surgery, faced the same difficulties. She decided to change her specialization and opted for pathology instead, which has a more predictable work schedule.

Recent researchers on the specialty choice of women doctors have also emphasized the need to account for welfare state policies like the provision of childcare

or family and maternal leave policies. Although I discuss these policies in detail in the next chapter, it is important to mention here that within the policy structure of Pakistan, the care (of family and children) is generally considered the responsibility of the family (and not the state), hence there is no provision of flexible work hours, or reduction in work timings to cope with the demand of familial responsibilities. Similarly, although labor laws in medical workplaces stipulate that a child care facility must be built for women employees, this policy is rarely implemented in most hospitals. Hence, most women have to rely on their families to provide care for children too young to go to school or for after-school care for older children. Moreover, where these childcare centers are present, they operate only during the daytime. Even the privately operated childcare centers (that are quite expensive and hence accessible to only a few women who can afford it) do not open at night. Therefore, for any specialties that involve night or evening duties, women have to rely on their families for support, which is not always easily available. Hence women tend to choose specialties where they do not have to rely on childcare facilities, and they start their career later, when their children are old enough to be in school.

Another factor that increases the time conflicts for women doctors is the cultural taboos related to working at night. In Pakistan, where honor of the families is closely tied to the mobility of women, staying out at night, even when it is for work, can be unacceptable for families. Because of these powerful cultural taboos, compounded by the lack of childcare facilities during night time, women tend to choose specialties where work is done primarily during day time. Fakhira, a 35 year old gynecologist, explained:

Our social setup does not allow women to stay outside the home after a certain time. If I have to work from 9 to 2, and during this time my husband is at work and my children are at school, this arrangement is somewhat acceptable. But if I have to do an evening or night shift after this duty, or leave home to take care of an emergency, this will never be allowed.

### **Gynecology and its others: Gendering the Medical Specialties**

Women doctors, while deciding whether a particular specialty matches their constraints and expectations, also consider the characteristics of the specialty, including patient contact, flexibility, type and diversity of health problems, prestige, pay and use of technology in that particular field (Bland, Meurer and Maldonado 1995). Moreover, specialty choice is also closely related to the personality type of the doctor and their personal values (Borges and Savickas 2002). Hence, women are often assumed to choose people centered specialties that involve long term contact with patients (like psychiatry or medicine), rather than technology centered specialties where the focus is on specific disease processes and instrumental interventions, like surgery for example (Barshes et al 2004; Mayer, Perez and Ho 2001; Stiwell et al. 2000; Buddeberg-Fischer et al. 2006). This is one of the reasons why, in Pakistan and rest of the world, women doctors are concentrated in few family-friendly and feminized specialties, especially gynecology and obstetrics (Jonasson 2002; Lambert and Holmboe 2005; Bland, Meurer and Maldonado 1995).

However, specifically in Pakistan (and South Asia more generally), the choice of gynecology and obstetrics as specialty for women is closely and intimately tied to their professional identity and status on one hand (Chidambaram 1993) and the cultural discourses about women's participation in paid work on the other. Part of the reason why

gynecology/obstetrics is considered suitable for women lies in the history of medical profession in South Asia. As I discuss earlier in the introductory chapter, women were accepted into the medical profession in South Asia only so far as they were needed to serve the needs of secluded women patients. The underlying assumption behind this segregation of work (in separate masculine and feminine spheres) in the medical profession was that women patients who practiced *purdah* would not visit a man doctor, even if it risked their health and life.<sup>41</sup> Hence, the British felt compelled to save the native women by establishing gender segregated hospitals for them. The earliest women medical professionals in South Asia were trained birth attendants and women doctors who worked as specialists of gynecology and obstetrics in women's only laying-in hospitals (Arnold

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<sup>41</sup> Interestingly, this assumption (that secluded women would choose only women doctors) has never been investigated. I have not been able to find any research based in Pakistan that suggests women who practice *purdah* will not see a man doctor. Some studies suggest that women in general prefer to visit a women gynecologist since women patients think they are able to relate better to their doctor if she shares their gender (Zuckerman et al 2002). Similarly studies also suggest that religiosity and age play an important role in women's preference for women doctors, particularly gynecologists and obstetricians (Rizk et al 2005; Schnatz et al 2007). Other studies suggest that it is the expertise and confidence in doctor's ability that matter more in choosing a physician rather than gender (Hill and Garner 1991; Victoor et al 2012). So evidence on this issue is inconclusive at best. During my own field work, I also observed that a woman patient's preference for a woman physician depended on a number of factors, including her own practice of *purdah* and modesty, and the attitudes of her family. Usually if a woman doctor was present, she was called for certain procedures and exams, like breast examination or catheterization. However, for routine visits, there was no visible pattern of preference. Both doctors and women patients also mentioned that Islam allows relaxation of *purdah* for medical treatment. Women patients mentioned that while they felt shy in consulting men doctors in some cases, they did not consider it immoral or wrong. Still, it goes on to highlight the fact that what matters is the perception, rather than the actual state of affairs.



2000). Hence, women were accepted in the masculine medical profession but only to do “feminine” work of caring for women patients.

The need to serve women patients’ needs is also the reason why medicine is considered an acceptable choice of profession for women in Pakistan, and since gynecology and obstetrics is a medical field particular to women, it is considered particularly appropriate for women doctors. However, this choice of specialty is not just an individualized career path choice. At least in Pakistan, the desirability of gynecology and obstetrics for women doctors is a reproduction of the spatial and symbolic order based on distinctions between masculine and feminine in the public sphere. Reproduction and giving birth are intimately associated with the female body, and thus part of the private, feminine, domestic sphere. Gynecology and obstetrics, being related to female reproductive organs and parturition (and hence, literally, a science of female body) is by extension considered women’s domain, and particularly suitable for women doctors. Although this particular pattern of specialty choice results from gender and work hierarchies resulting from specific cultural and social conditions in Pakistan, it can also provide insight into how specialties and certain career tracks are gendered in Western societies as well.

Gynecology and obstetrics is an interesting example of this gendering process in the United States as well. Until 1980, there were less than 20% women doctors working in gynecology and obstetrics, and gynecology was understood as a men’s science perpetuated by men on women’s bodies. Since then, this specialty has undergone the greatest gender shift, as more than 85% of specialists working in gynecology and obstetrics now are women. Research further indicates that this gender shift has occurred

through the trend of increasing interest of women in the field, and a simultaneously decreasing interest of men doctors in joining this specialty. Although the implication of this widening gender gap has been studied extensively for its implication for patient care, and changing practice in gynecology and obstetrics, the underlying sociological causes of this change are relatively unknown. Some authors do suggest that the perception that women patients prefer a woman gynecology and obstetrics plays some role in physicians' decision to join gynecology and obstetrics (though studies shows no actual preference for either gender in choice of gynecology and obstetrics by the patients). This is very similar to the situation in Pakistan, where the perception that women patients prefer women gynecologists has led to the conception that gynecology is a preferable specialty choice for women. In the discussion that follows, I will explicate on the reasons behind the choosing (or not choosing) gynecology and obstetrics in Pakistan.

#### Reluctant Gynecologists

Since the logic behind acceptance of women doctors in the medical profession (in Pakistan at least) is to care for secluded women patients, presumably for matters of health that are particular to women (read, gynecology/obstetrics), women medical students are strongly encouraged to join this specialty (Papanek 1971; Arnold 2000). Almost all the women doctors that I interviewed mentioned that they were strongly advised by at least one of their peers, family members or mentors to think about becoming a gynecologist, since as gynecologists they can help other women and make a real difference in other women's lives. Dr. Saira, a medical specialist, told me that her mother was strongly against her joining internal medicine as a possible career, "My mother always thought that I should help other women. Even though I explained to her that as a physician I can

help everyone, not just women, she is still against my decision.” Similarly, Dr. Lubna another doctor whom I interviewed, chose gynecology even though she liked surgery, “I felt that I could help women as a gynecologist, and that it would be more acceptable to family, since I would be treating women, and working with mostly women doctors.”

Secondly, becoming a gynecologist is also considered a financially secure decision. A women doctor practicing as a gynecologist will attract more women patients (since it is assumed that women prefer to see a woman gynecologist) as compared to, say, a women practicing as a surgeon or a medical specialist, since patients (both men and women) are assumed to prefer a doctor who is man for these subfields. The expectation of future earnings acts as a filter in specialty choice: As women are better paid in specialties considered suitable for them, they are more likely to join them rather than non-traditional specialties (Baker 1996). Because of these reasons, women doctors are channeled to practice gynecology and obstetrics, whether they prefer it themselves or not. Dr. Fazeela, a woman professor in a public hospital whom I interviewed, told me that she always wanted to study psychiatry. During her medical studies, she excelled in the subject and was encouraged by her teachers to continue post-graduation in it. However, she was married immediately after her house job and her in-laws insisted that she practice gynecology and obstetrics, since it was more lucrative financially. She practiced as a gynecologist for seven years for she finally quit. “I never liked being a gynecologist, so against my family’s wishes I changed my field. I started post-graduation in psychiatry. My family is still not happy, even now that I am a professor of psychiatry. They say that there was more money in gynecology. But money is not everything in life,” She told me. Similarly, Dr. Rabia, who is a gynecologist, told me that she decided before graduation

that she will specialize in gynecology, as she explained, “It does not matter what I liked to do or not. I had to think of something that would be acceptable to my family after I get married. As a gynecologist I would work with only women and make a decent amount of money. That is why I selected gynecology.”

Indeed, this preference is so strong that women doctors who have no specialized training prefer to work as gynecologists rather than general practitioners. Similarly, because of the gendered division of medical labor, women doctors hired as women medical officers (WMO's) in public hospitals often find themselves acting as de-facto gynecologists, sometimes against their choice. Dr. Aziza's story is especially telling in this regard. She wanted to specialize in internal medicine because she found the diagnostic work challenging and exciting. She joined a public sector hospital as a WMO and was posted at a small rural health center. However, instead of working as a physician as she originally intended, she found herself being designated as a gynecologist. There was already a man medical officer at the medical center who took care of all medical cases. The only patients she received were women, who came for gynecology/obstetrics related problems. Needless to say, it was frustrating for her, “I had zero training in gynecology/obstetrics. I had only conducted a few deliveries during my final year, and those were supervised. I had not even done any house job in gynecology. And now I suddenly found myself doing everything alone. Even the birth attendant (*dai*) at the center, who was not a doctor, was more skilled than me.”

At first, she used to refer all cases that required surgical intervention to the district health center, since she had never done a C-section. Then one day, a local man surgeon came to her office and told her that she could not keep doing that forever. Many patients

that she referred came from extremely poor, local families. It was difficult for them to get to her in first place. Referring them to a hospital miles away meant that most of them ended up in hands of a poorly trained traditional birth attendant (*dai*) instead of being treated by a doctor, which could be potentially life threatening.<sup>42</sup> He told her, “Take courage, doctor, and start doing C-sections. (*Hosla karain doctor sahiba, or bismillah krain*).” He supervised and assisted her in first few procedures until she became confident enough to operate alone.

Despite being quite skilled as a gynecologist after almost ten years of practice, Aziza did not give up on her dream of being a medical specialist. When her family settled in Lahore, she decided to finally start doing her post-graduation in medicine. Although she is older than most her co-workers now, most of whom started training with little or no gap, and there is a significant drop in her family’s earnings as she no longer works as gynecologist, she is happy that she is fulfilling her dream.

#### Being a “lady doctor” – or Not.

The desirability of gynecology for women doctors in Pakistan also reveals the complicated relationship of professional status and prestige with occupational segregation in medical specialties. Women doctors (even in Western countries like the United States and United Kingdom) tend to join specialties that are considered less prestigious, though it is unclear whether these specialties are more open to women because of being less prestigious, or increasing number of women has resulted in loss of prestige. Recently,

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<sup>42</sup> It is worth noting, and somewhat ironic, that he invoked the same reasoning that colonial officials used to discredit traditional medical women.

increasing numbers of women in the medical field, the feminization of medicine in other words, has sparked the fear that it will result in medicine (or at least a certain specialties) becoming lower-level pink collar professions, with loss of status, influence and monetary reward (Paik 2000). In Pakistan, similarly, even though gynecology and obstetrics is considered suitable for women, it is considered less prestigious than other specialties

A particularly interesting example of this strong connection is the phrase “lady doctor,” the somewhat outdated term used for women doctors. The use of gender specific occupational terminology (like lady doctor and manageress) is challenged by feminist linguists since it draws attention to presence of women specifically in positions of authority (Saul 2012). This suggests that masculinity in the position of authority is the norm and women are but an aberration (Moulton 1981), as further exemplified by absence of the term “gentleman doctor.” Though the use of this term has declined in the United States and United Kingdom, it is still used frequently in Pakistan in common parlance to refer to women doctors. However, in Pakistan, this term has acquired a culture specific, political meaning. Tracing its history and usage provides insight into the various tensions inherent in the struggle of Pakistani women doctors in forging their professional identity.

The use of this term in South Asia dates back to the documents of Dufferin Fund, where, interestingly, it was used to refer to any and all women who worked in women-only *zenana* wards and laying-in hospitals, which included doctors, mid wives, and even non-medical staff (Arnold 2000). Over time, this phrase came to be used for women medical professionals, reserved particularly for gynecologists (and occasionally trained midwives as well). This is the sense in which this phrase is used nowadays: a “lady

doctor” is not just a woman who is a doctor, she is also a doctor *for women*. The understanding that a woman doctor (or lady doctor) is, more than anything, a doctor for women, is so strong that in the Pakistani consciousness, woman doctor and gynecologist are almost synonymous. In common usage, if someone says that they are visiting a “lady doctor” it almost always means a gynecologist.

However, “lady doctor” is not always used in a neutral sense. British women doctors practicing in India used it in their reports in a derogatory sense to emphasize their position as professional doctors as opposed to the inept “lady doctors” of Dufferin Fund hospitals, who were discrediting Western medicine because of their incompetence (Arnold 2000). Even now, although gynecology and obstetrics (or being a “lady” doctor) is a desirable career path for women doctors, it is ascribed a somewhat lower status in the hierarchy of professional specialties. When I asked Hiba, a 23 year old fresh medical graduate, what specialty she would prefer, she told me “anything but gynecology and obstetrics because I really do not want to be a *dai* (a traditional birth attendant)”. Conflating the (assumed) feminine specialty with traditional women healers, and relegating both to an inferior status points to the gender subtexts inherent in professional socialization in medicine. Another young graduate, Fizzah, explained, “I really do not want to do gynecology. It is just messy and disgusting.” Naila, who chose to specialize in surgery similarly told me:

I think gynecologists are not good at anything. They practice some of the internal medicine but they are not good at it. If they have to manage even a basic thing like diabetes or blood pressure, they call medical specialists. They do some surgery, but they are not good at it either. If something is even slightly outside their area of expertise, they get confused and call surgeons.

Even senior doctors, while talking about gynecologists or gynecology as a profession, used similar derogatory terms. A senior professor talking about women gynecologists (and the need to restrict women in medical profession) for example said, “Women do not choose difficult specialties. They choose only gynecology, which does not need expertise. A non-skilled birth attendant (*dai*) will get same results as them. I think health department should estimate how many gynecologists are needed every year and admit women students according to that number.” Another senior professor of surgery in a meeting joked with his colleague, a woman professor of gynecology, that gynecologists do not really practice medicine, they merely stand by, remain “masterly inactive”<sup>43</sup> and watch as nature takes its course.

A further indication of this is found in the usage of the term “lady doctor.” In my interviews, and day to day conversations I noticed that almost everyone used this phrase for women doctors—their parents, family members, man doctors, patients, policy makers—but women doctors seldom used it. They always foregrounded their identity as medical professionals, by calling themselves just “doctors”, and in a way, stressing that they can and will treat everyone regardless of their gender. By this subtle move, women doctors try to claim a professional status equal to their male colleagues, and a professional identity that is not restricted to just a few specialties. This is a further indication that in the gendered ordering of the work in medical profession, women

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<sup>43</sup> A reference to the obstetric guideline “Masterly Inactivity and timely interference” for breach deliveries.



doctors are not passive subjects being assigned to various tasks. Rather, they actively participate in negotiating and contesting the boundaries drawn for their work.

### **Choices Have Consequences: Impact of Differential Specialty Choice**

As I discuss above, because of the expectation of work-life conflict in certain specialties and the desirability of gynecology and obstetrics, women are overwhelmingly concentrated in a few “women-friendly” specialties. These differential choices have a profound effect for Pakistan’s health economy as well as the training of future doctors.

As the number of women among new medical graduates continue to increase, and women doctors are constantly channeled in to certain specific specialties, there is a mismatch in the supply and the requirement of doctors in other medical specialties. In Pakistan, this situation is even more urgent, as a large number of doctors (the majority of whom are men) leave Pakistan to practice in other countries. As a result, there is a severe shortage of doctors, particularly in surgical and allied specialties like E.N.T (ear, nose and throat), orthopedics, neurosurgery and anesthesiology. Even in major public, tertiary care hospitals, job positions in many departments are vacant, because a suitable doctor is not available to fill the vacancy. This creates problems in adequate healthcare delivery as the relatively few doctors in these “deficient” specialties scramble to deal with an increasing patient load. In the department of E.N.T in a large public hospital, an assistant professor told me that there are less than ten medical officers in the whole department. Because of the patient load, and scarcity of doctors, each medical officer has a 24 hour work shift every other day (as compared to once a week in most department). Even the routine tasks of patient care (like daily examination), which are usually carried out by

house officers or medical officers, have to be done by consultants. This difficult work structure further deters other doctors from joining these specialties.

In Afridi Hospital, where I conducted fieldwork, several departments were chronically short of staff. Moreover, this deficiency was more acute in the junior faculty, which usually carries out bulk of patient care. Multiple posts in departments of anesthesia, ENT, pediatric medicine and surgery, chest surgery, oral and maxillofacial surgery, for example, were vacant, and have been vacant for many years, since there are no specialists available to fill these posts.<sup>44</sup>

Deficiency of doctors in some fields has become so acute that it has prompted the government to provide special incentives for specialists. Anesthesiology, for example, is especially important since no surgical procedure (and many medical interventions) can be carried out without adequate anesthesia and pain relief. The number of trained anesthesiologists in Punjab is so low that, in order to deal with this shortage, the Health Department of Punjab has offered to keep anesthesiologists on retainer for a decent monthly stipend and to provide them with transportation when their services are needed.

The deficiency of doctors in medical subfields also creates problems in the training of future doctors. Post-graduate training and specialization has to be done in the form of an apprenticeship with a senior expert doctor in the same field. Since doctors approved to train post-graduates are concentrated in a few urban centers, doctors from

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<sup>44</sup> And if someone does specialize in these specialties, they do not practice in a public hospital where the pay is abysmal. They prefer to join lucrative private practices. The price of this choice (or lack thereof) is paid by the poor patients who cannot afford quality health care, and suffer as a result.

other cities either have to relocate or choose another specialty. For example, the only centers approved to provide training in knee replacement surgery or organ transplant are located in Karachi, Pakistan, and doctors from all over the country have to move to Karachi if they want to specialize in these fields. Since it is usually more difficult for women doctors to move for their career, it means few women, if any, specialize in these fields.

The gender ratio also plays an important role in determining the culture of a specialty. Increasing the number of women in a particular subfield makes it easier for more women to join it in the future, as they have access to the advice and mentorship of women who are already working in a particular discipline. That is why women interneers prefer to join specialties which already have a substantial number of women. Dr. Najma, who specialized in Gynecology and obstetrics, for example told me that one of the major reasons why she chose gynecology and obstetrics was that the department faculty was predominantly women. “We all had similar problem, with work and home, and we could relate to each other,” she explained. In contrast, other specialties, for example orthopedic or cardiac surgery, have a “boys’ club” reputation (as one of my participants pointed out), and few women fit the image of an ideal worker in these department or feel motivated to do it. Dr. Samra wanted to specialize in Urology, which in Pakistan is an extremely masculine specialty. (In Lahore there is currently no woman doctor working as urologist, and I met only one woman doctor doing post-graduation in Urology). However, when she did her clerkship in a Urology department, she realized that it will not be possible for her, as she explained “It was a strange atmosphere there. All men. They were almost hostile to us girls, focusing only on the boys, and passing rude comments about women. I thought

to myself, someone stronger than I might be able to deal with it for four years, I simply cannot.” These differential choices also have consequences for those medical specialties where there is a women majority: there is an increasing saturation of doctors in these fields, particularly in gynecology and obstetrics, which is more apparent in the urban centers. There are fewer job openings in the public and private sector, and younger doctors have to work in an increasingly shrinking job market with low pay.

### **What Lies Ahead?**

As the discussion above indicates, increased representation in terms of the increasing number of women physicians does not guarantee an equitable position in the medical profession. The structure of medical education and training has hardly changed in Pakistan during the past century. This training process still assumes that the “ideal” doctor is a man, who is unencumbered with any familial responsibility. There is a culture of overwork in medicine further exacerbated by the cultural conception of the doctor as a selfless individual (as I discuss in next chapter) and maintained by the old guard in the medical field (of mostly men professors, supervisors and high level officials) who think that this is the only way to be a doctor. This work structure and workaholism that is expected of every doctor regardless of gender has consequences for everyone involved in medical work. Doctors of both genders suffer from excessive stress and burnout because of an inability to meet the demands of their career. Research on medical work also shows that tiredness and sleeplessness resulting from overwork can lead to physicians making more mistakes, with occasionally fatal consequences for their patients. Still, there is little demand in Pakistan to revise the training procedures, or to make it more flexible for women doctors, who do not fit in this image of “ideal doctor.”

As a result, although the number of women doctors graduating from medical colleges in Pakistan is increasing (PM&DC 2016), and this demographic change is bound to translate to an increased presence of women across all areas of the medical workforce, the gendered stratification in specialty choice, pay differentials, and practice settings are likely to remain. As the number of women increases in medicine, organization structures and functions are changing under the influence of the individual actions of women doctors, and a variety of sociocultural processes. The resulting feminization of medicine, and entrenched gender stratification in rank and positions, are merely a new form of occupation segregation, rather than equity and integration. With an increasing number of women among the younger cohorts, this pattern can lead to a serious shortage of women specialists in male dominated specialties. As the case of health care in rural areas in Pakistan suggests, turning a blind eye to the cultural and social restrictions placed on the paid work of women doctors can create problems for women both as providers of health care and their recipients.

## CHAPTER 8

### EQUITY IN THE WORKPLACE: ROLE OF PUBLIC POLICY

My big point is that everyone is cracking jokes about women in Pakistan becoming doctor and not going in the workforce. But nobody talks about the fact that system makes it categorically difficult for them to work in health force. There is no attention to provision of equal facilities, no on-site daycare, no feasible structure of calls or duties that is family friendly, and there is sudden increase in sexism and discrimination the moment you graduate and enter the workforce. And then somebody sums it up in a Facebook meme about women doctors not working!

These are the words of Noreen, a young Pakistani medical resident, and her words are evidence of the frustration that women doctors in Pakistan feel when they are faced by the policy structure of their workplace. As evident from her words, these structures are far from equitable.

Formal and realized public policy and its role in creating and sustaining social inequities is a well-studied area of research (Guy and McCandless 2012). Scholars of public administration, for example, point out the role of selective policy formulation, and implicit and explicit biases in the policy process in creating social inequity (Epp, Maynard-Moody and Haider-Markel 2014). Similarly, selective policy implementation and the attitudes of front line bureaucrats tasked with implementing a policy can impact the marginalization of social groups (Maynard-Moody and Musheno 2003; Oberfield 2014; Gofen 2014). In this regard, public policies aimed towards creating a more equitable workplace (like family and maternity leave policies) are of a special interest. As Joan Acker (1990) pointed out, organizations and workplaces are not gender neutral structures. Rather, workplace interactions, organizational policies and hierarchies all play an important role in producing and sustaining the structures of inequity within

workplaces. Hence, men and women often experience their workplaces in fundamentally different ways. Marginalization in the workplace through differential access to resources, opportunity structures or inability to reconcile the demands of employment with gender-role socialization or social values underlies the persistent occupational segregation based on gender (Charles and Grusky 2004). Hence, policies and reforms enacted by the state to create a more equitable workplace are especially important to ensure women's participation and retention in the workforce (Reskin 1993).

Although the impact of family and maternity leave policies on women's participation in paid work and their effect on the relative wages of women have been widely studied (Waldfoegel 1998; Baum 2003; Shonberg and Ludsteck 2007), little is known about the experience of women workers who participate in these programs, or the role of public administration praxis in the implementation of these policies. In Pakistan particularly, although several policies and laws are geared towards ensuring a more equitable work environment for both men and women, gender equity in workplaces still remains elusive as Noreen's quote indicates. In this chapter, I review various policies implemented in Pakistan to ensure gender equity<sup>45</sup> in the workplace and the experiences of women doctors of these policies (the details of these policies are given in Appendix C).

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<sup>45</sup> I am using gender equity policies in a broad definition to include the equal opportunity policies that allow women to participate in work on equal terms (like family and maternity leave, child care) and anti-discrimination policies (that prevent discrimination on the basis of gender or sex, like policies against sexual harassment).

## **Introducing Administrative Burden**

I use the theoretical framework of administrative burden to describe women doctors' experience of the policy processes related to their workplace. The administrative burden, defined as citizens' experiences of their interactions with the state as onerous (Burden et al. 2012) describes the citizens' experience of various policies related to their rights. To put it more simply, administrative burden describes whether individuals accessing a certain resource provided by the state were treated fairly and with respect, received what they deserved, and were provided the benefits intended by policies and programs (Moynihan, Herd and Harvey 2014). Administrative burden is produced throughout the policy process from imperfect policy design (where needs of certain identity groups are neglected in creating new policies) and uneven policy implementation (where even though policies exist, their selective implementation can actually increase inequity).

### **Administrative Burden and Equity**

What are the consequences of administrative burden for gender equity in workplaces? Public administration, through its role in policy creation and implementation, not only contributes to the marginalization of women in workplaces by enforcing discriminatory laws but also uses its discretionary power to further cement the unequal social norms prevalent in the society. Although multiple policies have been created to prevent discrimination against women in workplace, little is known about how women workers experience these policies. For example, the ostensible purpose of creating FMLA (Family and Medical Leave Act) in the United States is to lessen the burden on working women. However, statistics from the Department of Labor ((Klerman



et al 2012a; Klerman et al 2012b; Pozniak et al 2012) show that even though the option of family leave was available, less than 14% eligible employees used it. The utilization of family leave policies implemented by individual states is even lower. Even though research indicates that compliance with FMLA creates disproportionate administrative burden for the employers (Mayer 2013; Hengst and Kleiner 2002), little is known about the difficulties that workers, particularly women, encounter while complying with these policies.

### Cost of Doing Business with State

Administrative burden associated with various policies can be analyzed along three dimensions (Moynihan, Harvey and Herd 2014): *The learning costs* are the time, money and cognitive requirements that are needed to learn about a law, rule or policy. An example of this would be filling of the tax returns, where imperfect information about the nuances of tax laws may prevent some people from getting the refunds they deserve. *The psychological costs* describes the social stigma attached with participating in a program (Bartlett, Burstein and Hamilton 2004), or the loss of autonomy and self-respect that comes with receiving a benefit (Stuber and Schlesinger 2006). In United States, for example, finger printing or urine testing for drugs for social security benefits may be seen as stigmatizing. This loss of autonomy intensifies when applicants feel that they must alter their identity to fit the image of an “ideal” beneficiary assumed by the policy (Brodkin 1993; Soss 1999). And finally *compliance costs* are incurred by fulfilling various requirements for the participation in a program. For example, excessive documentation requirements for an application process may deter people from participating altogether. Decreased uptake of social security benefits like SNAP and

Medicaid in the United States because of burdensome application process in an example (Bartlett, Burstein and Hamilton 2004; Leininger et al 2011; Herd et al 2013).

Although some of these costs are involved in every policy process, administrative burden has a political dimension, since certain socially disadvantaged or marginalized groups face disproportionate difficulties to access their rights and benefits (Moynihan and Herd 2010). The distribution of administrative burden has important consequences for the social equity and justice as, through their experience of the policy process, certain groups learn that they are valued, their voices matter and they are equal participants in the political process, while other groups learn just the opposite (Soss 1999; Bruch, Marx-Ferre and Soss 2010). Moreover, the differential distribution of administrative burden is part of the “hidden politics” (Moynihan, Herd and Harvey 2014) in public administration, where even though formal policies may seem neutral or equitable, their implementation on the ground is different for different groups (Hacker 2004; Thompson 2012). Hence, to say that administrative burden is gendered means two things: First, even though gender equity policies are aimed at creating a fairer workplace, the administrative burden associated with these policies dictates that women doctors often do not receive the benefits intended by these policies. Secondly, many policies, even though seemingly gender neutral, create disproportionate difficulties for women in workplaces, as they fail to account for women’s need or the broader social context in which they are implemented.

Research suggest that, particularly in the case of family friendly policies, all of these processes play a significant role in the uptake of these benefits by women workers. For example, according to statistics provided by Department of Labor in the United

States (Klerman et al 2012a; Klerman et al 2012b; Pozniak et al 2012), even though approximately 60% of employees knew about these benefits, their information was often incorrect, as they assumed FMLA was broader than it actually was. Moreover, the majority of the leaves (approximately 40%) taken under FMLA lasted a very small duration, just 10 days or under. Thus, even though formal policies exist to help women workers, they do not receive the benefits intended by these policies. Moreover, research on maternity leave and flextime policies at the University of California also suggests that academic women did not utilize these benefits because they believed that taking leave or time off the work will be perceived as being less committed to their job and will incur penalties in the form of delayed promotion (Wolfinger, Mason and Goulden 2008). Similarly, the social stigma attached to paternal leave means that this benefit included in FMLA remains extremely unutilized (Halverson 2003). In research on family leave policies, it is also apparent that the attitudes of co-workers and administrators are more important than the formal policy structure in creating difficulty for women workers (Halverson 2003; Wolfinger, Mason and Goulden 2008; Bornstein 2000; Williams, Blair-Loy and Berdahl 2013). This also indicates that the interactions between colleagues, peers and family may interfere with how policies are actually realized and implemented on ground. Still we know little about the role of public administration in creating and maintaining inequity in workplace.

### **Family and Work: A Balancing Act**

One of the most important factor for women workers and doctors is difficulty in resolving their family responsibilities with their work. These family responsibilities can be financial and care giving. The traditional division of labor in which men are socialized

to be primary breadwinners and women are socialized to be primary caregivers is such that men do not face conflict between their work and primarily financial family responsibilities, as their paid work is considered their primary family responsibility as well. Women who are involved in jobs or paid work, on the other hand, have to constantly negotiate between the conflicting demands of economic independence and personal growth that come from work, and the need to care for their families and children. Similarly, family responsibilities change over the life course, beginning with the responsibility of starting a family, caring for new-born children, pre-school and after school care, and finally caring for the elderly. Hence, the nature and degree of work/life conflict that people face during the course of their life also changes. Below I will review policies that either directly or indirectly influence the care work and family responsibilities of women doctors in Pakistan.

#### Permission to Parent: Maternity Leave

Difficulties in employment resulting from pregnancy and childbirth are exclusive to women workers. Maternity protection and benefits, therefore, form the central aspect of women workers' rights. There are no specific antidiscrimination laws in Pakistan to protect against discrimination based on motherhood. Though Pakistan's labor laws stipulate that a woman cannot be fired or demoted during pregnancy, they also make it illegal to knowingly hire a pregnant woman.<sup>46</sup> Pakistan's labor laws also allow all women workers at least 12 weeks of maternity leave (6 weeks before and 6 weeks after

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<sup>46</sup> The West Pakistan Maternity Benefit Ordinance 1958; The Mines Maternity Benefits Act 1981.

childbirth) that is fully paid, and this law applies to all public and private organizations. Any woman employed for at least 4 months can use this maternity leave. Women who are employed in the public sector can receive 90 days of maternity leave, for a maximum of three times during their entire career.<sup>47</sup> Moreover, this maternity leave is only for biological mothers (women need to prove their pregnancy to use it) and does not cover motherhood through adoption. This policy is similar to what is offered in neighboring South Asian countries (for example, India, Bangladesh, Sri Lanka and Nepal have similar labor policies, though there is a proposed, as yet unratified law in India that seeks to extend this leave to 26 weeks). In medical institutions, new fathers can also receive a ten day paternity leave if they so choose.

While this maternity leave policy seems progressive on paper—which it certainly is for many women workers in Pakistan—important administrative and legal factors continue to limit its effectiveness for women doctors. First, there are restrictions on how many times maternity leave can be taken by a woman worker depending on where she is employed. For example, women workers including doctors who are regular employees of public sector organizations can apply for a paid maternity leave for up to a maximum of three times during their entire career and any maternity leave thereafter is unpaid. In contrast, women doctors who are doing post-graduate training in various public and private hospitals are not regular employees and can apply for only one maternity leave during the entire duration of their four year training (per College of Physicians and

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<sup>47</sup> The Civil Servants Act 1973; Revised Leave Rules 1980.

Surgeons of Pakistan CPSP rules, though the Punjab government is allowing for a second unpaid leave for medical trainees).

Applying for maternity leave also incurs various compliance costs. To apply for maternity leave, a woman doctor employed in the public sector has to inform the health department and the institution where she is working of the approximate date her leave would begin (that is, her expected date of delivery). If she is a post-graduate trainee, she also has to inform the institution which oversees postgraduate training. She has to file multiple applications to her training supervisor and head of department informing them of the approximate time when her leave will begin. For this, she is required to attach a medical certificate and an ultrasound image, both of them confirming the pregnancy and expected date of delivery. The certificate and ultrasound image has to be provided by or attested by a publically employed doctor above a certain rank. These applications are then sent to health department for approval.

It should be noted that maternity leave is almost never denied; all of the participants employed in public hospitals who applied for maternity leave received it on full pay. However, there are significant costs associated with it. The requirements of filing multiple applications with countersignatures is a tedious process itself. To complete it, women doctors often had to excuse themselves from their duties, or request a friend to take their place. Getting the signatures was also not easy. Adversarial attitudes and sexist comments during this process makes for a harrowing experience. Saba, a post-graduate trainee, was pregnant with her second child when she approached her departmental chair to sign her maternity leave application. She signed the application with a sneering comment from the chair that if she wanted to produce babies she should have stayed at

home (*bacahy paida kernay hain to ghar baitho*). The comment had a profound effect of Saba, “That day, I came home and I almost decided to give it all up. For a moment I could not see any point in continuing. I was struggling every moment at home for my job, and my effort was not even appreciated. I thought why am I doing this? Is it even worth it?” Naima, a young doctor, similarly had to apply for maternity leave very early in her training. Instead of signing her application, her supervisor refused to keep her on as a post-graduate trainee. Although because of maternity policy she did not lose her job, and received full pay, she had to approach another advisor, explain why the first advisor refused to work with her, and start her training all over again.

This administrative burden does not just end with the application process. Doctors are required to complete a certain duration of training to complete their post-graduation, and they have to make up the time lost during maternity leave by doing an extended training. While doctors receive their full pay during their maternity leave, the extended training (equal to the duration of maternity leave) is unpaid. This policy effectively makes the maternity leave unpaid. Finally, doctors have to provide proof of their training to be eligible for post graduate examination, and in every subsequent hiring and promotion process. Each time they have to prove that they made up for the time lost in maternity leave during their training, adding significantly to the time and psychological cost of filling more forms and getting additional signatures by their advisors.

The policy of restricting the maximum number of maternity leaves a woman can take, especially during post-graduate training, is also particularly onerous for young women doctors, as women generally have little say in reproductive decision making in Pakistan. They neither control how many children they will have nor the timing of the

birth, since such decisions in Pakistan are always made in the context of extended family, and elders, particularly mothers-in-law, play an important role in a family's reproductive decision making. Due to long standing cultural factors and pressure from extended family members, most newlywed couples in Pakistan prefer to have (at least two) children in the first few years after marriage. Since most women doctors generally get married just before or after the start of their post-graduate training, they are often under the maximum pressure to "produce" children during the early period of their post-graduate medical training. This is also the time where the medical training is most demanding and time consuming; most specialties have more than 80 hour work weeks in the first two years, with mandatory 24 and 36 hour duties and ward weeks (where a doctor is required to live in the ward for a week). Hence, the restrictive maternity leave policy often becomes a bone of contention between young couples as they try to balance the demands of family, work and society at the same time.

Saima a 28 year old doctor was in the third year of her postgraduate training when I interviewed her. She had her daughter during the first year of her training. Now she was under tremendous pressure from her in-laws to have another baby, but she did not have any maternity leave left (as she is not formally employed), and this put her in a difficult spot:

My mother-in-law and everyone else among my in-laws keeps asking me, when are you having another baby? Are you people even trying? I don't know what to tell them, or even how to respond. I can barely manage duties with a toddler, and I do not know if I can get another maternity leave. I have two more years of training left, and I do not know if I can keep saying no to my family for that long. Sometimes, if your advisor is a humane person, he or she can give you an unofficial leave, and not report it to CPSP. But that is a big if.



Other women doctors have to go to extreme lengths to plan their families to match the requirements of these policies, and sometimes even that may not be enough. Fareeha, a post graduate trainee in her second year, for example, recounted her experience of maternity policies:

I knew of maternity leave policies beforehand, so when I got married, my husband and I decided to have a baby immediately before I started post-graduation. Then, I had my second daughter in my first year of training, because I thought if I can produce two babies early (*ager main do bachay paida ker don*), then I can do my training in peace. Now, the problem is both of my children are daughters, and my mother-in-law wants a grandson. She and everyone else in my family keeps asking us when are you going to give us a grandson. I know I will have to produce another baby soon. Frankly, I do not know what I would do if it is not a son.

Saleema, a third year resident in radiology, got pregnant for a second time during her training. She was not a regular employee so she was not entitled to a paid leave. When she applied for an unpaid leave, her supervisor referred her case to the Dean of the medical institution. Saleema nearly wept while recounting her experiences:

He was worse than a mother-in-law. He kept telling me that this is a work place, not a baby factory. And did I not hear about something called contraceptives? I could not say a word. It was like I was being ground between two stones in a mill (*chakki kay do paat kay beech*). One man (my husband) forces me to get pregnant and another one berates me for it.

Saleema's predicament shows how women doctors in Pakistan experience the two overlapping patriarchal governing systems of state and family. On one hand, in the context of the family, women are reduced to bodies employed in a system of biological and social reproduction. On the other hand, in the context of a capitalist state, they are penalized for their biological capacity for reproduction, which makes them less than ideal and productive workers. These compliance costs of ostensibly family friendly policies and maternity leaves are not specific to Pakistan, though. In a survey of academic faculty

in University of California, 31% women academics reported that they planned their pregnancies in such a way that babies are born during sabbaticals or summer breaks (Wolfinger, Mason and Goulden 2008). Moreover, research indicates the fertility rates in most industrialized countries are falling below replacement levels because women find it difficult to balance paid work with child rearing (Brewster and Rindfuss 2000). However, in Pakistan, these compliance costs increase manifold, since it is not the women who are making the decisions regarding the family formation, or even the conjugal couple. Like career choice and arranged marriages, family formation is also a decision that is made in the context of an extended family where elders, particularly mothers-in-law, can significantly affect these decisions (Kadir, Fikree, Khan and Sajan 2003; Jejeebhoy and Sathar 2001).

Take the example of Ghazia, a woman surgeon who was married in the third year of her surgical residency. At that time, she had two more years of training left. Both she and her husband (who is also a doctor) agreed that her training schedule would not allow her to care for a child, and both of them agreed to wait until after her training was completed to have their first child. Even though her husband was supportive of her career, this decision was difficult to explain to her in-laws who constantly asked Ghazia when she was going to have a baby. Eventually, it was Ghazia's husband who took the blame on himself, saying that it was he who had decided to not have a baby so early in their marriage. This example underscores how the intersection of restrictive policies by the state with a patriarchal familial structure can create difficulties for women doctors. While the decision to delay family formation was acceptable if a man did it, it would

have been impossible if it was Ghazia who made that decision, or if her husband did not agree with it.

More importantly, parturition is not a mechanical and predictable event, recovery from which can be guaranteed in six weeks. In a country like Pakistan, in many cases there is a complication in childbirth, and the mother needs a longer time to return to work. However, there is no stipulation for extending the maternity leave in such cases. In contrast, women doctors employed in public sector are a little better off since they can apply for a sick leave, an earned leave or extraordinary leave (which can be unpaid or 50 per cent of their original pay) for some duration, but approval of this leave is solely on the discretion of the hospital administration and there is no guarantee that it will be approved (The Civil Servants Act, 1973; Revised Leave Rules, 1980). Moreover, the process to apply for this leave is quite tedious and requires approval from several bureaucrats, again exposing women to sexist attitudes of front-line workers. Hania, a women doctor employed in a public hospital as medical officer fell seriously ill after the birth of her second child. With her illness and caring responsibilities of two children, it was difficult for her to go back to her job, so she decided to apply for an unpaid, extended leave. However, despite her difficulties, her leave application was denied. Eventually, she used her family connections to persuade the administrator to approve her leave. Women doctors employed in the private sector or postgraduate trainees (who are working on contract) do not have even this recourse. They have to rely on the discretion of their advisors and immediate supervisors in the case of an extended illness.

## Breast Feeding in Workplace

The maternity benefits policies provide for up to six weeks of leave after childbirth. However, the requirement of caring for a child continues long after that. Although workplace policies stipulate that every institution that employs 50 women or more should provide childcare facilities on premises where women can breastfeed during meal breaks (Factories Act 1934, Section 33 Q; Punjab Factories Rules, 1978), in practice such facilities are not ubiquitously available (I discuss them in detail below). Even when present, child care facilities are reserved for children only and there is no place to breastfeed. Similarly, although labor policies suggest that women be given regular breaks in addition to meal breaks for feeding their babies, few people know about these provisions (Factories rules, 93 Section 33-Q). Lack of a proper space and the need to maintain modesty in the workplace is so strong that many women doctors that I interviewed either decided not to breast feed their babies at all or weaned them very early. Not only does this have significant emotional and psychological costs for the new mother, it also deprives children of proper care. Naila, a 29 year old pathologist, knew she would have to return to work after her maternity leave ended, so she decided to wean her daughter early. “Those were really painful days for me,” she recounted. “My daughter cried, and that just triggered the let-down reflex.<sup>48</sup> But I could not feed her. I developed mastitis due to congestion”. Bina, a 32 year old pediatrician, also weaned her son around three months when she returned to work. It was source of great anxiety and shame for her

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<sup>48</sup> The let-down reflex stimulates breasts to produce milk. It can triggered by the crying of the baby.

as she told me, “I tell other new mothers to feed their babies for at least two years. I tell them how beneficial breast milk is as compared to bottle feed. What kind of a mother and what kind of a doctor does that make me?”

Perhaps more distressing is the fact that even if breastfeeding policies are changed, and adequate provision is made for lactating mothers, there is little likelihood that this situation will change. The norms of modesty and purdah in Pakistan are such that women do not feed their babies in front of anyone else (whether in home or in public places). Perhaps that is why Pakistan has one of the lowest breastfeeding rates in the world. Dr. Paressa is head of the department in radiology, where most of the doctors are women. She told me that she campaigned hard to provide a room for new mothers, but no woman doctor was willing to bring their baby along for breast feeding because of modesty. Eventually she gave up on her proposal.

#### Childcare Facilities

Another important provision that helps women’s participation in work is the establishment of childcare facilities. Historically, few hospitals and medical institutions in Pakistan had childcare centers for their women employees (even though a large number of employees, particularly paramedical staff and nurses, were women). Women doctors had to rely on their families to care for their children if they were working, and if such support was not available, it became impossible for them to work. However, recently, the Pakistan Medical and Dental council has made it mandatory that every teaching hospital and medical institutions should provide for a dedicated childcare center (as mentioned in Criteria for evaluation of Medical institutions, Pakistan Medical and Dental Council, available at its website). As a result, in many hospitals, new child care

centers have been built to cater to the needs of women doctors and other women employees, improving the situation somewhat. Still, there are many factors that continue to inhibit women's access to proper childcare facilities. Many of these childcare centers often have an age limit and do not accept very young babies. Thus, women with infants have to either rely on their families to provide care, or they have to look for alternative arrangements, and each of these options have penalties of their own. Similarly, almost all daycare centers operate only during daytime office hours. This is particularly significant for doctors who regularly have to do night and evening duties, especially during the early part of their careers when their children are young. While they can use childcare centers during the day, they have to depend on their families or hire private maids to look after their children during evening and night shifts.

Relying on family for care is not always easy, as family members might not be available or willing to take the responsibility of a young child. In the economics of domestic work, asking family members to care for children always comes at a price. Living in patrilocal families, with an extended family system, this can be particularly different since young mothers, as daughters-in-law, have little say in domestic arrangements, and they cannot often count on their family-by-marriage for support. Selma, a 30 year old doctor, is a mother of two. While she was doing her post graduate training, her institution did not have a childcare facility. She left her children with her parents-in-law. However, this strained her relationship with her mother-in-law, since the mother-in-law had to bear the burden of extra household work. Selma was regularly told that she was a bad mother since she preferred to work, while ignoring her children. To ease the burden of work for her mother-in-law, Selma hired a maid to look after her

children, even though she could barely afford it with her salary. This arrangement did not work out either. The maid was often asked to help with other domestic chores, while the children she was hired to watch were ignored. One day, Selma came home to find her daughter bleeding from the forehead. Left unattended, she had fallen down the stairs. Frustrated, Selma decided to place her children in a privately run childcare center. Faiza, a woman doctor of 28, was doing her post graduate training when her first child was born. Though she lived with her in-laws, they refused to care for her child. Now a mother of two, every morning she packs her children's belongings and drives them across the city to her mother's home to drop them off before going to work, and then picks them up again on her way back.

In many cases, even when childcare facilities are present, they remain extremely underutilized. Even though the majority of my participants had young children, very few of them had used childcare facilities, which was very surprising for me. Raina, a 32 year old doctor, is the mother of an infant son, who is cared for by her mother-in-law, even though the institution where she works has a childcare center. I asked her why she did not use childcare center, which would have been much more convenient. Her response illustrates how, without proper implementation, changes in policy structure do not translate into meaningful change on the ground. She told me, "When my son was born, someone told me of the new childcare center. When I went there, I was horrified. It was a dimly lit hall, with no sunlight and no windows. There were no toys, games, books or activities; just a row of hospital beds, which they had recycled from some ward, along the walls and threadbare rugs on the floor. Older children were swinging the baby cots, and younger ones were huddled on the floor. There were only two maids looking after all

those children. I decided at the very moment that I am not sending my child here.” Even though childcare facilities are built, they are just to pass the minimum requirement set by authorities. As a result, they are often ill-equipped and under staffed, so doctors are often reluctant to use them.

Still, even with bare minimum facilities, childcare centers are extremely helpful in facilitating women doctors’ work, especially those who do not have any other support structure. Fareeha, an assistant professor in a private medical college, has two young children. She uses the onsite daycare center for her younger daughter. This center, which I visited, was similarly spartan, with only very basic facilities, no air-conditioning system, and no backup power (very important in Pakistan where sweltering heat and power outages make summers brutal). Although she was not happy with the existing situation, she told me that it was still better than nothing. Both her parents and parents-in-law lived in another city, and without the childcare center, it would not have been possible for her to continue her job.

Another important factor that prevents women from accessing childcare services is the social stigma attached with their usage. The ideal mother, not just in Pakistan, is someone who stays at home and provides round the clock care for her family. Performance of this ideal motherhood is important for social acceptance. To outsource childcare, even when it is demanded by the mother’s career, is seen as selfish. To choose to work over being a full time mother is seen as preferring yourself over your children, which goes against the ideal image of a selfless mother. The prevalent ideology of intensive mothering in Pakistani society not only creates guilt and stress for women who leave their children in the care of others, but also incurs social penalties.



Zareena is a mother-in-law to two women doctors (all three families live in a single multigenerational home). One of them works full time and leaves her children at a day care, the other has left her career and is a stay at home mother. She told me how she viewed these two different strategies, “There is always an effect on children. No one can substitute a mother. The children of this one (who does not work) get better grades, they are healthier. My other daughter-in-law works full time for her own happiness. Her children are being brought up by God knows who at those awful centers. They are not as good, and this is to be expected.” Zareena’s comparison of her two daughters-in-law provides an idea of the norm of mothering that is required by women and the social stigma attached to digressing from this norm by with using childcare.

#### The “Sandwich Women”: Caring for Elderly

In multi-generational living arrangements of the Pakistani families, it is the young women of the families who bear a disproportionately high burden of caring for both aging parents and young children. The phenomenon, commonly called the sandwich generation, describes the dilemma of a generation caught between the demands of childrearing while caring for aging elders, particularly in Western countries. However, the situation is somewhat different in Pakistan, where multigenerational families living together often pool their financial resources to some extent. Particularly in middle and upper class families, the parents’ generation is usually the most affluent and bears the financial burden of living together. However, the burden of domestic work is still borne by the women, creating a particularly difficult situation for working women. Caring for the elders however, is not recognized in the labor policies of Pakistan, and no provision is

available for decreased workload, or flexible work hours for someone involved in long term caring for an elder.

### **Assuming a Man's body: Gender Neutral Policies**

Many of the policies that I discussed above are targeted measures that are intended to facilitate women's participation in the labor force, and make the workplace more equitable at a national level. Equity in the workplace and in organizations, however, involves many macro and micro level processes and policy structures that are ostensibly gender neutral, i.e. they are not directed particularly towards a specific gender group. However, many of these processes assume the image of an ideal worker, usually a man. Though gender neutral on surface, these policies play a significant role in maintaining the gendered nature of workplaces.

Perhaps the most important and often cited example is the structure of medical work itself. In medical organizations, the standard employment structure assumes the ideal worker as someone who can give infinite time to their work, and is unencumbered by conflicting demands on their time from other areas in life. This is exacerbated by the culture of overwork in medical workplaces, where doctors are expected to serve their patients first and foremost, often neglecting the needs of their families (McCall 1988; Green 1995).

In the United States and the United Kingdom, doctors usually have an upper limit on their workload (eighty hours per week) (Hutter et al 2006). Even this requirement (which usually translates to a 16 hour work shift per day in a five day work week) may be difficult to follow for women with small children, or those who have to also shoulder the full responsibility of caregiving work. In Pakistan, on the other hand, there is no upper

cap for weekly workload. In many clinical specialties, continuity of care is considered an important learning experience and medical residents, especially in early years of training, are expected to live in the hospital (twenty four hour long continuous work shifts in medicine and ward weeks in surgery are a norm). 36 hour and 48 hour work shifts, in which residents rotate between emergency, outpatient and ward duties, are common in clinical specialties. Though these timetables are applicable equally to men and women, it is women who are disproportionately affected. Not only do these “gender neutral” schedules mean that the majority of women doctors prefer non-clinical or diagnostic specialties (where work structure is somewhat more manageable), they are an important reason for the marginalization of women doctors in the health workforce.

Furthermore, the institutional structures and policies not directly related to the workplace assume that providing care is the primary responsibility of the family, not the state, and that a dedicated care-force is available constantly to support the workforce. In this division of labor between state and family, the state only assumes the responsibility of providing education to children, where education is interpreted rather narrowly as merely imparting knowledge in schools. Hence, public and private schools in Pakistan have a half-day schooling structure, with no school lunches. In most schools, the school week is five days, each day begins at 8 am, and ends in the early afternoon (around 12 for younger children and around 1 for classes with older students). Families are required to provide transport to and from schools, and school snacks. In most Pakistani households, all these services are provided by the women in the family. In contrast, most hospitals start their work at 8 am and duties end at 3 pm (even later for some private hospitals). In surgical specialties, work in public hospitals begins even earlier, at 6 am, and there is no

specific time when a shift will end. Surgical procedures and operations can sometimes take much longer than anticipated and operating personnel stay as long as the procedure takes, sometimes even taking responsibility for the post-operative care. But schools do not provide after school care, nor is the provision of childcare adequate in workplaces, as I discussed previously.

These conflicting time demands have multiple consequences for women doctors and their families. Dr, Hala, a 34 year old pathologist, described her routine as follows, “My shift ends at 5pm but my son’s school ends at about 1pm. Thankfully my parents live nearby so they pick him up. My home is on the other end of city, so by the time I pick him up and get home, it is already past 8pm. Then we do homework till 11pm. Sometimes I have to sprinkle water on his face to keep him awake.” Bareera, a gynecologist, drops off her children every day at her parents’ home before going to work, and picks them up afterwards, adding several hours of commuting time to her schedule. In fact, the inability to comply with these demanding work hour policies is one of the most frequent reasons that my participants mentioned for decided to leave workforce, or not to start their career at all (approximately 70% of women not working as doctors mentioned the difficult work schedule as a reason why they did not join work force.)

Similarly, a central induction policy, recently introduced in Punjab, is presumably aimed at creating equity in hiring post-graduate trainees, and to ensure merit based admissions. This scheme, at least as far as health managers are concerned, will improve the delivery of health care to under-served peripheral areas as it will mandate rotation of doctors to the underserved areas. Although this policy is applicable to both men and women doctors (and men and women doctors that I interacted with during my fieldwork

were equally critical of this policy), it creates disproportionate difficulties for women doctors. For one, under this policy doctors can be posted anywhere in the province for their training. Women doctors are particularly vulnerable because of cultural restrictions on their mobility. Their families may be willing to allow women doctors to work within the area of their primary residence, but for most Pakistani families it is unthinkable to move primarily for a woman's career. If a woman doctor is posted to a different city, her family may demand that she leave her career altogether rather than allowing her to move. It should be mentioned that this problem is not specific to Pakistan. Research indicates that women workers are less likely to move because of their career, and particularly in dual earning couples, it is the wife's career which pays the penalty in the "two-body problem."

The Public Service Code of Pakistan does advise that if both husband and wife are public servants, they should be posted in the same city and transferred together (the "wedlock policy" Establishment Division's OM No. 10/30/97-R-2, dated 21-4-2006). However, this policy covers only a small fraction of publically employed women doctors, and the policy implementation, especially in regards to doctors, is often erratic. Dr. Asia, an assistant professor, and her husband are both public servants, but she and her husband were posted to cities several hundred kilometers apart. Although the decision was eventually reversed, she had to file a formal petition for it, and then use the influence of a local politician to get an early hearing. The process still took her several months and countless trips to the health department. In the meantime, she had to report to her new appointment or face disciplinary action, creating an impossible position for her family. Other women doctors, whose husbands work in the private sector or in a different

profession altogether, do not even have this policy to fall back on. Their only hope is often to cite their family difficulties, or use political influence to avoid transfers. This is then seen as asking for undue favors, which creates the image that women doctors are unwilling workers in the health force.

Thus far, I have discussed the policies and laws that are directly related to the work structure of women doctors. Public administration is also involved in the day to day running of public hospitals. The penalty of being a woman in a masculine workplace is also created by the micro aspects of the policy process. In fact, for the phenomenological experience of the workplace, these micro-processes are much more important and insidious, since they are often difficult to recognize, and tough to articulate.

One particularly illustrative example is the issue of gloves. In every health care settings, gloves are a staple, for hygiene and to protect doctors and patients from countless contagious diseases. If you have ever been to a doctor's exam room in, say, the United States, you may have noticed two or three boxes of gloves hanging on the wall, each dispensing a different size. In public hospitals of Pakistan however, gloves are available only in one size (if they are available at all), which are usually too large for most women. It would be an otherwise minor, almost unnoticed thing, but during my field work, I have seen many doctors utterly frustrated by this small, almost daily irritation, which keeps reminding them that they don't *belong*. Sana, a surgeon, told me that during operations, blood often seeped inside the gloves too large for her hands, so she took to adding rubber bands at the sleeves. Still, one day she found blood of a patient (who was hepatitis C positive) inside the gloves. After a scary few days (thankfully she did not contract the disease), she started buying her own gloves. Many other doctors,

similarly, found it difficult to rely on their sense of touch in overly large gloves, crucially important as doctors use their sense of touch to distinguish how soft a cervix is, or whether it is a vessel or nerve they are holding, or whether the lump they are palpating is filled with fluid or solid. Many of the women doctors buy their own gloves, or ask patients to buy a smaller pair for them. This might seem like a small thing at the outset, but to many of the doctors, it is the daily reminder that they remain invisible within the policy structure of their workplace.

### **Role of Administrators**

In the discussion above, I have discussed the equity footprint of various workplace policies and regulations. Perhaps the most important factor that affects the policy design as well as its implementation is the attitude of managers and policy makers themselves (Meyers, Glaser and Donald 1998; May and Winter 2009). The immediate bosses of women doctors within medical workplaces, as well as bureaucrats in the health department, are the “front-line” bureaucrats that act like gatekeepers when women doctors are accessing maternity or childcare benefits. Their sexist attitudes, snide remarks, and teasing during the application process and afterward create a hostile environment for women, where women come to believe that they do not legitimately belong in the workplace. It should be noted that these frontline bureaucrats are also socially situated individuals, who have internalized the social norms of their society. Their attitudes are merely reflective of the broader patriarchal social order which they represent (Lee, Learmonth and Harding 2008). More importantly, the language used by health managers suggest that instead of a legitimate and legal right, they considered family benefits a “concession” that was provided to women workers. A health manager

for example, talking about the women doctors in his hospital suggested that women have already been facilitated enough through various policies and laws, and that further policy and legislative change was unnecessary for gender equity. The dean of another medical institution suggested that since several provisions have been made for women doctors in terms of maternity leave and child care, “They need to work a little harder and show that they are committed to their career.” Hence, accessing family benefits meant that women had to not only prove they were deserving of this concession by working harder, they also had a greater burden to prove that they were valuable members of health care workforce.

Another most important factor that contributes to discriminatory policy structure and implementation is a lack of participation in the political process by women doctors and a lack of advocacy on their behalf. Women doctors are generally excluded from policy making, since they are under-represented in the policy structure and administrative hierarchies. Associations and organizations (like the Young Doctors’ Association, YDA) that lobby on behalf of doctors often do not articulate women doctors’ problems. Further, most health managers at medical institutions and health department think that their legitimate “clients” are the patients (who are the recipients of health care). Doctors, in this view, are merely workers in the supply chain of healthcare. The intention of policies (even when they are aimed for doctors) is to improve care for patients; the actual providers of this care, doctors, are not considered the beneficiaries of the policies. The impact of the policies on doctors’ career or work is often ignored as an acceptable price. A high level health official talking about the recent policy changes including Central Induction Policy, for example said, “I know doctors are angry with us (health department), but the 18 hundred million common people are happy with these policies.”



### **The Bite of Administrative Burden<sup>49</sup>**

More importantly, the price of these administrative burden is not paid simply by the women doctors (the obvious beneficiaries of these policies). In the studies of administrative burdens associated with welfare policies, various costs are usually analyzed only from the perspective of the immediate beneficiaries (but see, Heinrich 2015). However, as I discuss above, imperfect design and implementation of family benefits not only create psychological stress for women (Hyde et al. 1995), it also deprives their families, particularly children, of the care they deserve. Lack of breastfeeding facilities deprives children of working women of their right of proper nutrition, which proper policy reform can change (Guendelman et al. 2009). Lack of childcare facilities creates stress and difficulty not just for mothers but for children as well. Moreover, the lack of effective policy structures in the workplace is an important reason behind the attrition of women doctors from the health workforce. Since the state spends an estimated \$8000 to \$10000 to train each doctor, the loss to the economy of Pakistan caused by the departure of women doctors is enormous (Abid 2014). The resulting shortage of doctors means that Pakistan has one of the lowest physician to population ratios in the world (around 15 physicians per 10,000 population in urban areas, around 4 per 10,000 population in rural areas). To compare, the United States for example has 360 physicians and the United Kingdom has 280 physicians per 10,000 population (World Health Organization 2010). The social and economic cost resulting from the insufficient delivery of health services is not difficult to imagine.

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<sup>49</sup> The title is an homage to Carolyn Heinrich's (2015) article of the same name.

## **Conclusion**

Let us now return to the question of gender equity in the medical profession in Pakistan. As the discussion above indicates, addressing administrative burdens is an important aspect of ensuring equity in medical workplaces. Importantly, workplaces form an extension of the social and cultural structures in which they are embedded, and without addressing the sexist attitudes in broader society, it is not possible to understand, much less remedy, the gendered nature of administrative burdens. This chapter highlighted the importance of heterogeneous sociocultural processes ongoing within organizations and outside of them in affecting the administrative burden and social equity in workplace. As the account of gendered patterns of policy process in Pakistani medical workplaces suggests, organizations and individuals exist and work within the gendered power structures prevalent in the society in which they are embedded (Acker 1990). Gender differences at the macro level in social institutions and at the micro level in everyday social interaction are part of the same complex system. As scholars like Foucault (1977; 1980), Bourdieu (1990; 2002) and Butler (1993) have argued, formal institutional policies, laws, and regulations are only one aspect of structural and formal barriers that intersect the life choices of individuals. More subtle modes of disciplinary control, exerted by formal and informal social institutions (like family, peers and colleagues) are much more important in influencing and sustaining social asymmetries. Thus, even though written policies exist to help women participate in paid work, the patriarchal social structure that devalues women's work, the gendered distribution of domestic and care responsibilities, and sexist attitudes prevalent in workplaces are more important in creating and sustaining inequities in Pakistani workplaces.

This discussion also highlights the gendered role of public policy in health care. The state acts as a policing authority for the boundaries of the medical profession by crafting and implementing policies that can directly affect the work of physicians (Ehrenreich and English 2010). However, the state is not simply an altruistic agent, as it represents interests of a certain class, and its policies can be seen as a continuation of the patriarchal social order in Pakistani society. Even though overtly discriminatory restrictions on women's medical careers have mostly disappeared (and are quickly challenged if re-introduced), more subtle changes in the training structure and workplace policies that I mention above still disproportionately affect women's careers. Lack of investment in facilities and policies beneficial for women's careers shows that state policies and processes often mirror social and cultural attitudes generally prevalent in society. Women's domestic work in the private sphere is expected to be unpaid, and taken for granted in neoliberal economies, and similarly their care work in public sphere is also devalued and underpaid (Riska and Wegar 1993).

The issue of equity in workplace is thus much more complex than the current policy of "add women and stir." It has to deal with the underlying social and cultural context that sustains these structures. In research on gender equity and resultant policy reforms that address it, cultural inputs are not accounted for, as they are conceptualized as noneconomic. As a result, their gendered nature and their intersection with work, paid or unpaid, remain obscured. To this end, conceptualizing work beyond the dichotomies of paid and unpaid, and highlighting the economic aspects of ongoing social processes in the so-called private sphere can lead us to a better understanding of why, despite multiple

measures, gender inequity still remains, not just in medicine in Pakistan, but across the world.

### SECTION 3

#### THE WORK OF A DOCTOR

Those people were lucky,  
Who cared only for their Work,  
Or considered Care their only Work.  
We were occupied every moment of our lives.  
We cared some, and worked some.  
Work interfered with our Care,  
And Care kept interrupting our Work.  
So, tired of this struggle,  
We forsook both of them, unfinished.

(Care<sup>50</sup> and Work—Faiz Ahmad Faiz, in *Nuskha hai Wafa*)

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<sup>50</sup> I have taken the liberty of replacing *Ishq* which has no translation in English with care.



Figure 10. The Patient Load: Worn out Marble Steps of a Public Hospital

Why do women doctors leave their career after investing so much and so long in their education?

To some extent, this was one of the biggest questions in my mind when I started this research project. As I explore in following chapters, the answer to this question was neither straightforward nor easy.

To begin with, this question assumes that working, defined rather narrowly as a paid job, is the normative ideal, a necessary pre-requisite to be considered modern, emancipated, empowered. It also assumes a certain ontology of work, where work is an activity that produces tangible, appreciable goods that can be traded or at least valued in a market. This assumes a certain world, where every person, to be recognized as an individual, must participate in such activities. This is a kind of world where relational

ethics have no place, where care is either invisible or has no value. The real question for us to ponder is not why women leave their work; rather, it is whether we wish to live in a world where this is only activity that remains.

## CHAPTER 9

### QUESTIONING THE BOUNDARY OF WORK IN THE MEDICAL PROFESSION

“How can you say that I have not worked?” Said Jahan, a 54 year old woman doctor. We were sipping tea in her beautiful home. The table in front of us was laden with delicious, home-made delicacies, testament to the Jahan’s skill in kitchen. Jahan, a graduate of King Edward Medical College, was accepted in medical college at a time when women could only apply for a total of twenty percent of the positions in Pakistani medical colleges. Her alma mater, one of the oldest and most prestigious medical institutions in Pakistan, selects the brightest among the applicants, and she was one of the only ten women in her class. Like many other women doctors in Pakistan, Jahan was married immediately after she graduated. As her doctor husband pursued a postgraduate degree in the United States, she had to put her career on hold, first because of the long, tedious and expensive procedure of obtaining a license to practice in the United States, and later to care for her children while her husband completed his work through an intensive residency. When they returned to Pakistan, her husband landed a well-paid job at a medical university, and Jahan found herself, yet again, putting her career on hold to care for her children and her ailing and aging parents-in-law. When I met her, it had been almost 30 years since she graduated. As far as the state of Pakistan is concerned, Jahan has not practiced medicine even once after she graduated. She is one of the proverbial “doctor brides” (Zakaria 2013), women who became doctors and were then lost to motherhood and marriage. Therefore, I asked how she felt about not working as a doctor. The vehemence of her response surprised me:



I have worked very hard, every moment of the past twenty years. I have made dinners and lunches, drove my children to school and back, taught them and helped them with homework, nursed my parents-in-law during their illnesses, and at nights, prepared lectures and presentations for my husband. Isn't all that work? So how can you say that I have not worked?

Jahan and women like her are the very examples that representatives of the state and senior medical educators in Pakistan like to cite when they insist that the admission of women students in medical colleges should be limited to certain percentage (Abid 2014; Khan 2015). And yet, as Jahan insists, she had never stopped being a doctor, or working as one. She has provided medical care to her children and her extended family during their illnesses, prescribed antibiotics and managed multiple chronic illnesses. For years, she was also the go-to doctor for her community. Women would stroll into her drawing room with their kids in tow seeking medical advice for ailments ranging from a mild flu, an ear ache, and a hookworm infestation to tuberculosis and pneumonia. When women in her neighborhood cannot seek antenatal care because of financial hardship or familial restriction, Jahan looks after them. Through her contacts in the medical community, she maintains an active referral network, directing patients to appropriate medical care wherever possible. Even though she is involved in providing medical care to her family and community, these activities count neither as work nor as medical practice, and it is difficult to understand why.

About a year ago, as I was going through the rituals of proposal writing for my research project and thinking about sampling, I had written (and assumed) that I would be sampling women doctors who were currently practicing medicine, and those who were not. This dichotomy of working/nonworking, practicing/non-practicing that I had assumed has created an epistemological conundrum. The experiences and stories of Jahan

and many other women like her constantly challenged and exposed the tenuous, artificial, and porous nature of this superimposed dichotomy. No matter how I tried to construct a boundary around the concept of medical work, or practice in medicine, something was always left behind. The problem here is with the very definition of medical work, and what counts legitimately as medical practice. As Jahan's story shows, the boundary between work and non-work is much more complex, and this continuum engenders several instances of silence and debate.

In this chapter, my focus is on these practices of healing (which I have termed the informal practice of medicine) that are unpaid and home-based. This particular practice of healing by women doctors of Pakistan that are not formally employed in paid work continues to problematize the boundary of work and not-work in medical profession.<sup>51</sup> Unlike other occupational settings, where the boundary between work and non-work is often fuzzy, changing and constantly negotiated, the boundary of medical work is fixed and policed rigorously by the medical profession. Only the work of healing (diagnosing, treating, advising), done by a medical professional authorized by the state and recognized by the medical profession at a place regulated by health codes is recognized as legal medical work/practice. Without this authorization, and outside the boundaries of the clinic, any work of healing is either illegal as unauthorized medical practice or “not-

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<sup>51</sup> Almost all women doctors that I interviewed practiced informally to varying extents. 34 of them were formally employed as doctors (four of them were unpaid), 15 were unemployed, three were formally employed as well as involved in paid private practice, and four were involved in paid, homebased private practice.

work” (that is, all the activities that are bracketed under the various types of nursing care).

This has important consequences. In clinical settings, limiting medical work/practice to “doctoring” means that the practice of healing done by non-doctors (nurses, paramedical staff) is not recognized as medical “work”. This particular organization of work and care plays an important role in the division of labor and hierarchies of status between the medical work of a doctor and care work by nurses. Although the overlapping of emotional and technical labor in various roles, and the dimensions of care and work in healing practices of both nurses and doctors has been widely studied (Good and Good 1993; Fisher 1995; Atkinson 1995; Joyce 2005; Tjora 2000), there is still a persistent differential in pay, status and autonomy between doctors (who do legitimate medical work) and nurses (who do medical non-work i.e. care). However, even though the definition of medical practice plays an important role in this division of labor, the mandate of the medical profession to claim legitimacy of medical work remains largely unproblematized.

Moreover, many scholars have noted the complex continuum of relations of care across clinical boundaries (Allen 2000; Yates-Doerr 2012; Yates-Doerr and Carney 2015) and stressed the importance of emotional labor and care work performed in the clinical setting above and beyond the technical work (Fitzgerald 2004). Still, the spill-over of medical work beyond its visible boundaries and its practice in extra-clinical settings

remains under studied and almost invisible in research.<sup>52</sup> This is especially significant in countries like Pakistan where a lack of regulation results in a myriad of medical practices often unrecognized in existing literature. An investigation in this medical work not only provides an alternative understanding of medical practice, but also sheds light on the politics of in/visibility of work in labor markets.

In the discussion that follows I first discuss how the professionalization of medicine has resulted in a specific organization of work in the medical field. I highlight the political consequences of such organization that creates gendered and classed hierarchies between doctor/not doctor and work/not work. I then explain how the boundary between medical work and care is blurred in Pakistan because of a lack of regulation by state. This lack of regulation allows for novel, nontraditional patterns of medical practice to emerge which are not possible in Western countries. I then discuss narratives of my research participants that highlight how this informal practice is important for providing health care to many people in Pakistan who are not able to access health care. I also emphasize how this work, even though it is unpaid, is an important source of empowerment for women doctors, and how their experiences problematize the assumption that participation in paid work is equivalent to empowerment. Finally, I discuss the possible implications of these non-traditional work arrangements for the traditional work in medical profession

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<sup>52</sup> I want to stress that by practice of medicine I mean practice of conventional biomedicine, and not alternative or complementary medicine, which are well studied and well recognized.

## **What is Work Anyway?**

“Definitions belonged to the definers – not to the defined” (Morrison 1987, 190 in *Beloved*)

It is difficult to define work. If work is the activity, tasks and functions that all of us perform, requiring physical and mental strength, then every act of living is work. In common usage, people may agree about what counts as work versus play or leisure. However, the debate begins as soon as the question arises whether an activity legitimately counts as work or not. In sociological theory and research in 20<sup>th</sup> century, work has increasingly come to be synonymous with paid work, or paid employment, firmly located within the domain of the masculine, public sphere and abstracted from biological and social reproduction (Braverman 1998; Gluksmann 1995; Tranced 1995). This narrowly constructed definition has been challenged in multiple areas. The boundaries of what can be termed as “work” have been problematized by the rise of the informal sector, in the form of sharing economies (AirBnB and Uber, for example), monetization of crafts with its mantra of doing what you love and conflating personal connection and friendships with economic transactions (Etsy, Ebay and thousands of vendors on Instagram, Snapchat and Facebook, to name a few) (Abrahams 2008; Luckman 2013), and co-opting play-labor for capital generation via social media giants like Facebook and Twitter (Fuchs 2016). Feminist challenges to the public/private dichotomy have similarly led to the identification of the changing nature and social value of work tasks based on the social area in which they are performed and the interconnectedness of multiple activities that cut across multiple areas of living (Hartmann 1981; Tancred 1995; Glucksman 2005; 2013). This has resulted in the complete reconceptualization of not only activities like

voluntary work (Wilson and Musick 1997), care work (England 2005), domestic work (Rollins 1985; Romero 1992) and emotional work (Hochschild 2000; 2003) but also play, leisure and unpaid work (Sayer 2005; Weeks 2007; 2011).

### **Professional Medicine: Monopolizing Medical Work/Practice**

How do we begin to define what the practice of medicine is? Is taking care of the sick by diagnosing, dispensing medicine or performing other care tasks considered the practice of medicine? If that would be the operating definition, women have always practiced medicine and healing, in one form or the other. In South Asia for example, traditional women healers practiced as “*dais*” and were often the only healers for women and children (Arnold 2000; Soman 2011). They were skilled in their craft, passing their knowledge from mother to daughter, sharing expertise with their neighbors and learning by apprenticing with experienced healers. They were an integral part of their communities as they went roaming from home to home and village to village, providing care and healing to the sick. Women were also trained as physicians in *Unani* or *Ayurvedic*<sup>53</sup> traditions, learning the basics of diagnosing, cultivating herbs and learning to use them, safeguarding and transmitting medical recipes (*nuskhay*) as part of family tradition. More importantly, taking care of the health of the family, especially children and elderly, has always been part of domestic work or care work that women in Pakistan (and South Asia) do in their homes. Even now, various teas (*joshanda*) and remedies (*totkay*) brewed in home (usually by a woman) are the first medicine most people in

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<sup>53</sup> Traditional medical systems widely practiced in South Asia before colonization and still popular in some areas.

Pakistan take, and for many minor illnesses, these remedies usually suffice. The recipes for these herbal medicines are exchanged between neighbors, transmitted from mothers to daughters and even shared by “wise women” (some of them medically trained doctors) on television shows geared towards a feminine audience. While this particular healing role of women is all but ignored in the halls of the medical profession, its economic impact is not lost on pharmaceutical companies. Palliative and over-the-counter medicines like cough syrups, medicines for fever and pain, and various rubs are marketed primarily towards mothers, emphasizing their healing role. However, even though women have been taking care of the health of their families and their communities, their work does not count as legitimate medical practice and remains invisible as “not-work.”

The practice of medicine as we know it today is not simply diagnosing, healing and treating someone. It is a “radical monopoly” (Illich 1973), tightly controlled and regulated by a complex conglomerate of predominantly masculine state and professional medical organizations. The net result of this monopoly is that certain activities are considered legitimately work and economically productive, while others are not. Indeed, diagnosing, healing and treating someone (caring for them, so to speak) outside the monopoly of the medical profession might be illegal and a criminally punishable offense. The medical profession is a complex network of multiple actors—the state, professional associations, medical organizations and institutions—that governs every aspect of medical care through its multiple disciplinary apparatuses: It defines and controls what can be legally called medical knowledge, allowing certain medical traditions to be taught and practiced legally, while others are deemed harmful and banned. By regulating and monitoring medical institutions, state and medical organizations control where and to

whom this medical knowledge and training can be disseminated (historical exclusion of women from medical schools, or special quotas for certain regions in Pakistani medical schools is an example). The purpose of these technologies is to guard the boundaries of the medical profession almost jealously and to maintain its status and its appeal. Like every profession, the aura of medicine lies in its esoteric, specialized, intangible knowledge (Evetts 2013). By defining what constitutes legitimate medicine (as of now, a narrowly defined, predominantly western, masculine tradition of allopathy), the profession of medicine establishes sole control over medical knowledge, its production, organization, dissemination and regulation. State laws and statues define what legally constitutes the practice of medicine, and what does not. Banning abortion, for example, makes it an illegal practice of medicine. Similarly, CPR and any resuscitative measures carried out by bystanders or first responders are not medical practice (even though they require medical training and knowledge). This had led to promulgation of Good Samaritan laws in multiple countries to protect helpers from any liability of wrongdoing and subsequent suing. Every country also defines who can be legally a doctor within their borders through its own licensing standards, requiring a series of specific educational and training requirements, various examinations, and payment of a certain amount of fees.<sup>54</sup> Moreover, since medicine is a constantly changing field, many countries also require doctors to remain constantly engaged in (legally defined) medical practice, or in continuous medical education.

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<sup>54</sup> So medical organizations like Women on Water that provide abortions and birth control to women where these services are not allowed by state literally practice outside the borders, usually in ships in international waters.



Though these practices are ostensibly aimed at ensuring safety and public health, and a certain standard of medical education and practice, it is necessary to be reflective of their political significance. Through its surveillance, regulation and control, the state monopolizes the axis of knowledge and power in medicine (Foucault 1980). It dictates what constitutes medical knowledge and truth, and through this, it creates multiple hierarchies of legitimate/illegitimate, doctor/not doctor, and practice/not-practice. The stakes of this professional monopoly are high: defining medical knowledge means economic and political control of medical institutions and the status, prestige and power that comes with it (Ehrenreich and English 2010; Roberts 2009). Controlling medical care also regulates, constraints and disciplines every set of practices associated with medicine, allowing bio-political apparatuses to decide who is sane and who is not (by constructing definitions of mental disorders through International Codes for Diseases, ICD -10, for example); which bodies and processes are normal and able and can just *be*, and which are not and need to be modified, excised, or deemed to live an unlivable life (Butler 2004a; 2004b), who can control their body and how much by regulating reproductive rights, eugenics and end-of-life care, and ultimately who lives and who does not (Rabinow and Rose 2006).

Medical historians would have us believe that the professionalization of medicine is the result of the triumph of scientific medical knowledge over quackery, and that there has always been a dedicated scientific tradition of medicine from Hippocrates to Salk to the present. However, the struggle to establish the boundaries of medical practice and medical care is inherently political (Ehrenreich and English 2010). For one, the professionalization of medicine is overtly gendered (Donnison 1977). It is the triumph of

masculine “medical profession” over women healers and lay practitioners (Witz 2013; Ehrenreich and English 2010). As the practice of medicine became monopolized, women healers in South Asia and across the world lost their status, respect and independence. Their knowledge was reduced to old wives’ tales, their practices were deemed dangerous, and they were excluded from the forbidden medical knowledge (Arnold 2000, Ehrenreich and English 2010).

When women were allowed to practice medical care, it was only under the supervision of (predominantly men) doctors, in subordinate positions. Women, from their previous status of independent healers, were reduced to being workers in the health industry. Though women still make up more than 75% of the health workforce in Pakistan and across the world (World Health Organization 2008), a majority of them work as nurses, or lady health workers. They still perform the bulk of healing and nurturing work: As nurses, it is they who are responsible for giving medicine on time, changing wound dressings, keeping an eye on changing symptoms, and feeding and bathing ill bodies. As lady health workers, they go from home to home, taking care of mothers and children, disseminating knowledge about reproductive health, hygiene and nutrition, and providing vaccinations. They are the backbone of any health system, not just in Pakistan, and yet their practice of healing is excluded from practice of medicine.

The control of the medical profession is also political because it represents the interests of certain classes and ethnicities. British bio-medicine was introduced in South Asia as a concern of a colonial state, taking care of its hapless, primitive subjects (Arnold 2000). It simultaneously discredited flourishing and well established local medical traditions of *Hikmat* and *Ayurveda*. Local physicians eventually became nothing more

than quacks and their practices were outlawed and banned. It was the British educated middle and upper class that accepted and preached the superiority of modern medicine, and provided patronage to professional doctors. In Europe and the United States, a similar pattern of discrediting women lay practitioners and solo healers through a systemic onslaught of a male-organized medical profession representing the interests of landed, upper classes and the state was involved monopolizing the practice of medicine in hands of professionals, and protecting it from the infringement by non-professionals (Ehrenreich and English 2010).

Even now, the structure of licensing requirements serves to establish a clear hierarchy of medical training, professionalization and knowledge. Doctors trained in Western countries have less of a burden of proof to establish their competence and expertise than others, since the licensing requirements by state and medical profession in various countries are selectively applied. For example, the Professional and Linguistic Assessments Board (PLAB), Certificate of Eligibility for Specialist or General Practitioner Registration (CESR or CEGPR or article 14), various identity checks and linguistic competence tests in the United Kingdom and United States Medical Licensing Examinations (USMLE), verification of degrees, English language proficiency tests (like TOEFL) and American recommendation letters in the United States are required only for doctors trained in certain countries but waived for others. This implies that the medical knowledge produced and disseminated in certain countries is superior to others. The financial and time costs to understand and fulfill these licensing requirements effectively prevents doctors from practicing outside the boundaries of the nation state.

Through this particular organization of medical work, and localizing legitimate medical practice within the bounded areas of the legally defined “clinic”, the medical profession creates a hierarchy of work practices. Hence, as the medical work of “doctoring” becomes increasingly visible through the standardization of medical care and a variety of health indicators measuring wellbeing, the work of healing becomes invisible. Even though formal medical practice is a type of care work (an exchange of healing service for a monetary reward) the disciplinary boundaries around the legitimacy and competence of medical work have multiple important consequences. First, formal public medical practice is understood as a *job* that is done within the confines of particular occupational contexts, which may be clinical (either in organizational or individual private practice setting), or non-clinical (as a researcher, academic, insurance advisor, etc.). This is not to say that physicians are not motivated by empathy or altruistic intentions: multiple medical charities across the world (Doctors without Borders, for example) and doctors providing relief services in war zones and disaster-struck areas are few examples where medical work is volunteered. Nor am I overlooking the complexity of medical care within the confines of the “clinic”, where emotional and technical labor overlap in the different occupational contexts of doctors and nurses (see, Fitzgerald 2004; 2008 for example). I do want to problematize however, the tendency of bounding legitimate “doctoring” and medical work within a clinical context, since the clinical act of situating medical care necessarily entails that certain forms of medical work are deemed more economically productive, visible and valuable for society, while other forms are rendered invisible, not-work and unproductive.

## Organization of Medical Practice in Pakistan

Although the professionalization of the medical profession has occurred more or less along the same lines in South Asia as well, the particular cultural and social conditions have produced slightly different forms of medical practice, which continue to challenge the established boundaries of the medical profession. Even though local medical traditions were discredited and mostly replaced by modern medicine, they continue to exist, often synergistically with modern medicine (Leslie 1998). The need to provide medical care in rural areas (where there are fewer doctors) has resulted in the recruitment and training of traditional dais as skilled birth attendants, often the only providers of maternal and infant care in many rural areas of Pakistan (Jokhio, Winter and Cheng 2005). Even gynecologists and obstetricians employ dais, not only as medical attendants, but also to utilize their reach and social networks in their communities.

More importantly, medical work in Pakistan is understood in completely different terms than in Western countries, and the boundaries of care and work strongly overlap even in legitimate medical work. Wajeeha, a woman doctor, for example explained, “People think doctors are *maseeha*. That we can heal them no matter what. People come to us at the end-stage diseases and they expect us to perform miracles. It is frustrating at times.” The metaphor of *masseha* (literally a messiah, or a Christ-like person) indicates that a doctor is understood as a savior and a deliverer, who heals miraculously with her touch. A doctor, most of all, is understood as people’s healer, who is not confined to clinics and does not need a referral for insurance purposes. Jameela, a 34 years old woman doctor, explained, “People think that doctors are serving the humanity (*insaniyat ki khidmat ker rahay hain*). They do not think that it is a skilled work (*paisha*) or a waged

work (*rozgar*). They do not want to pay the doctor, they just want to be healed. But doctors have to pay the bills too, and feed their children.” This image of medical work as a service or vocation results from the powerful cultural ideal that care must always be altruistic, an act of selflessness done out of love, and any activity ceases to be “care” when it is paid for and bought. Dr. Jameela further explained, “People come to us with nothing, and they say, save us. They expect us to perform miracles. And we do as much as we can. We buy drugs for them or pay for their tests in they cannot afford it. Doctors here work in hospitals without pay because they want to serve. Because this is our training.” This particular view is held to a great extent by both producers (doctors) and consumers (patients) of medical work. A doctor is understood to have a “duty to serve”, no matter what the circumstances are. Doctors themselves are socialized during their education and training to strive to the ideal of selfless and noble service.<sup>55</sup>

Moreover, unlike many Western countries, where prescription drugs are regulated and their sale controlled and monitored, drug sales are very different in Pakistan. Though prescription medicines carry a standard warning on their packaging, “To be sold on prescription of licensed medical practitioner only”, all drugs (including sedatives and potentially addicting drugs) are sold as over-the-counter products, with little regulation

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<sup>55</sup> Though with increasing economic austerity, this ideal is difficult to follow and preach, and it has important consequences for the status of medical profession of Pakistan. Younger generations of doctors have to contend with increasing job saturation and cost of living. This difficult financial equation has forced them to demand better pay, and a regular service structure, something that is seen as nothing short of betrayal of ideal messiah image, by public, state and senior doctors. The result is decreasing respect for doctors and increasing incidences of violence against them when “care” was refused. See Riaz and Bhaumik (2012) for doctors’ struggle for better pay structure.

and oversight. Medical investigations like bloodwork and imaging can be bought and ordered over-the-counter. This freedom and lack of control opens up spaces for the practice of informal medicine that are not possible in many Western societies.

This understanding of medical work as a service, overlapped with the relative lack of regulation of medical services and medical substances, means that the boundaries of clinic are essentially blurred, and medical care can be given, and sought, freely. It is not uncommon for people to ask a doctor outside her work place or work hours to treat them and prescribe medicine. Thus, medical expertise and occupational skill becomes overlapped and entangled with other social connections, resulting in very different ways of doing medical work. Because of this, the practice of medicine in Pakistan has never been confined to clinical settings, as I will discuss below. It is this extra-clinical practice of medicine that provides a way for us to conceptualize medical work beyond its legal boundaries, and in its myriad of forms. In the narratives below, I highlight how this informal practice of medicine is important not only for the families and communities of women doctors as they provide medical aid to those around them, it is also important for women doctors themselves as it allows them to continue to practice healing.

### **Work as Care**

The first time Fareeha, now a medical graduate, practiced medicine was at the end of her third year in medical school. She had returned home from college on a break to prepare for an upcoming professional examination (“profs” for short). In a routine gathering of neighborhood ladies for tea, a friend of her mother took Fareeha aside for her medical opinion. She was suffering from headaches and tiredness, and her doctor, finding no apparent cause, had referred her to a psychiatrist. Fareeha was unsure how she

could help, but she was also obligated to help her mother's friend, and somewhat elated to act like a doctor. Using a spare bedroom as a make-shift examination room, Fareeha examined her and found lumps in her armpit. She advised her patient to get them checked at a hospital, but she told Fareeha that her husband had refused to pay for any more medical visits, saying that her illness was "only psychological." Fareeha took a plain white page, and just as she has seen her seniors doing it, wrote out a medical prescription for fine needle aspiration and cytology. Her patient was diagnosed with cancer the next week.

This is simply one of the instances of how medicine is practiced outside its narrow, legal definition. As a medical student and as a subsequent doctor, this aspect of practice for Fareeha was constantly intertwined with the "clinical" practice of medicine, and the beneficiaries were many. Sometimes it was a neighbor with sudden low level of blood sugar who could not drive to a hospital and who consulted her at home. Sometimes it was her maid, who wanted her advice, since her working hours prevented her from going to a public hospital, and she could not afford a private doctor. During weddings and parties, there are always a couple of women who take her aside for her medical opinion. Even though Fareeha does not practice as a doctor, she keeps her tools nearby at home a stethoscope, a sphygmomanometer, a thermometer and a couple of tongue depressors. She keeps a few common medications at hand as well, since her patients cannot always afford to buy them. "I even have a safe delivery kit at home that someone lent me. You never know when you are going to need one," she told me solemnly (Figure 11 and 12).





Figure 11. Work-life balance: Stethoscope, Hairpins and Lipstick in a Woman Doctor's Handbag

It is difficult to find parallels for this practice in the research literature. It is not medical pluralism, that is, the practice of medical traditions other than biomedicine (like homeopathy, say). Most women doctors who practice informally are trained in conventional biomedicine, and it is conventional medicine that they practice. It is not volunteer work, for even though it is non-remunerative, volunteering retains some aspects of paid work. Volunteering is often an organized activity, with a formal schedule, and a specified “work” location (Wilson and Musick 1997). Women doctors practicing informally do not volunteer at free clinics, or work pro bono. Their patients visit them at their homes, and women doctors stop the domestic *work* that they are doing, put the mop aside, or stop making *roti* (flat bread), wash the flour off of their hands and go listen to their patients. Their patients stand in their kitchens and are examined in whatever room happens to be unoccupied at the moment. Their prescriptions do not have water marks

and identity features on them, but are written on paper torn from a note pad, or a lined school notebook. It is different from home-based work,<sup>56</sup> which almost always has a remunerative value, and the person doing it is considered formally employed even though the primary work site is at home. Remuneration for the informal medical practice in Pakistan is on the other hand not expected or demanded from either side, doctor or patient. It is offensive to ask money from a patient who has come to one's home and asked for help. It is also different from merely helping out, like running errands for a neighbor, because these medical interactions are much more formal, and even though they take place outside the formal clinical setting, doctors treat them as doctor-patient relationships, often going at length to protect the privacy of their patients. Many doctors take their patients to a separate room, and some even set aside a room in their homes for

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<sup>56</sup> Defined here as those forms of employment where the primary work site is home. Examples include tele-working, and various homebased industries.

this purpose.



Figure 12. A Woman Doctor's Closet: Medical Care/Work Permeates all Areas of Life

The most obvious beneficiaries of this care work are, of course, immediate family members. In fact, the idea that women doctors can provide the best possible care to their children and families is one of the main reasons why women doctors are preferred as potential spouses and daughters-in-law in marriage match making, as I discuss in Chapter 4. Though both Fareeha and her husband are doctors, it was Fareeha who cared for her parents-in-law whenever they fell ill. When she got married, her mother-in-law was already a diabetic. It became part of her routine housework to check her blood sugar level, to administer insulin and to keep a strict schedule of diet. When she developed an open sore as a diabetic complication, it was Fareeha who set up and cared for her intravenous line, administered antibiotics, and performed regular debridement of the

wound by scraping off necrotic tissue. Raheela, another doctor practicing informally, cared for her hypertensive father-in-law for several years, prescribing medicine and monitoring his blood pressure regularly. When he was hospitalized after a stroke, because of her medical expertise she remained with him in the hospital, feeding him through a naso-gastric tube and changing his posture regularly to prevent bed sores. The labor of healing which is usually distributed across multiple agents (family, nurses, and doctors), with demarcated boundaries and job descriptions, hence becomes part of the same work/care continuum, practiced without distinction.

This practice is especially important for people who cannot either afford medical care or cannot access it readily. Fareeda, a 34 year old woman doctor, had worked in a primary health care facility for several year. She had to leave the job when her mother-in-law (who lived with Fareeda's family) suddenly had a stroke and was paralyzed. Between providing medical care to her and taking care of her three young children, it became impossible for her to continue her paid work. However, she had built a reputation in her neighborhood as a doctor, and people still continue to consult her for their medical needs. She thinks that she is helping people now more than she ever did when she was "working", as she told me:

The women who do domestic work in my neighborhood live in a slum nearby. There is no doctor there, nor any public hospital. They are paid so little that most of them cannot afford even the most necessary care. So they come to me because they know I am a doctor. Sometimes it for themselves, for routine gynecology related matters. They want to know about a contraceptive, or cannot afford medical care during pregnancy. Sometimes they need help with their children. Because of sanitary conditions where they live, hook worm infestation is almost endemic, and most children and women are severely anemic. So once a month I go there and distribute [drug] and iron supplements.

Farina, a 34 year old doctor, similarly lives in an urban community that is adjacent to a slum (*kachi abadi*). Women and children who live in this area often visit at her home for their ailments, and she keeps a supply of medicine at her home to distribute to those who cannot afford it. Since these women practice informally in their homes, they are available round the clock, and since they do not charge anything (sometimes even supplying the drugs free of cost to their patients), their work is extremely important for their communities.

Nazia, a 36 year old doctor, was not formally employed as a doctor when her family moved to a remote valley in northern Pakistan because of her husband's job. Nazia was seven months pregnant at that time. She realized that in the whole district there was no woman doctor, or any trained nurse. A local religious faction had issued a religious edict (*fatwa*) that women were not allowed to go outside their homes or travel without their male kin (*mahram*). They threatened to kill any woman health worker who defied their order, so even though there were public primary health care centers, their buildings were empty and deserted. Because of her own pregnancy she was acutely aware of the problems faced by women in that area. So she decided to see women patients at her home. "I could not provide care for every woman. Just those who were brave enough to come to my home, but still I think that made a difference." She told me, "Because of these problems, children there could not get polio vaccinations. So I asked local polio workers to give me some vaccine when vaccination campaign started, and I gave it to children who came to my home."

With the availability of mobile technologies, like Skype and various mobile chatting apps, this informal practice of medicine often transcends local distances, even

entangling with formal medical practice occasionally. In the hospital department where I conducted my fieldwork, women doctors had created a social media group of their cohorts. It was a diverse group, a mix of specialists and general practitioners with different areas of expertise, some practicing only informally, working both inside Pakistan and outside of it. Whenever one of them encountered a difficult case, they shared their findings and patient histories with the group, and then collectively worked back and forth to help the patient. Women doctors working outside the confines of the hospital thus become embedded in their professional communities and neighborhoods in ways that would not have been possible otherwise. Since they do not charge anything and usually are available around the clock, they are able to provide medical care for people (mostly women and children) who are unable to afford it, or cannot access it.

### **Work as Empowerment**

Because of this idea of constantly being a doctor, it is not possible to apply the conventional classification of practicing/non-practicing, or working/not-working to the experiences of Pakistani women doctors. They work seamlessly in many settings, often simultaneously, the only difference being that they are paid for some services and not for others, and it is the non-paid services that are often relegated to the category of non-productive and non-work. Participation in paid work is often considered a marker of women's empowerment and a proxy for gender development (Kabeer 2008). Still, the exact connection between these aspects remains under theorized, even problematic, especially in contexts where participation in paid work does not significantly change the power relations within the other areas of social organization especially family (Pearson 2007). The informal practice of medicine that is always unpaid, and takes place outside

the boundaries of legitimate paid medical work, not only stresses the need to focus on subjective experiences of empowerment, but also to challenge the theoretical and empirical emphasis on production of capital as the sole determinant of empowering work. Even though women doctors are not paid for their services, they are able to practice their craft of healing, an important part of their self-identity. Their sense of empowerment comes from being able to help other and making a difference, rather than participation in paid work.

Ghazia, a 42 year old woman doctor, for example had to leave her job after her first child was born. She had a very good working relationship with her patients there, and they insisted that they wanted to keep seeing her. “I see them at my home now,” She told me, “they refuse to go to anyone else even though I am not working. They say healing is in my hand (*meray hath main shifa ha*)” Even though Ghazia insists that her patients don’t pay her, it has become a source of pride and satisfaction for her. She is able to continue her work, and it is the sense of joy that she derives from helping her patients that is a source of strength for her. For many women doctors who are not formally employed, this work becomes an important part of their subjectivity. It allows them to maintain a connection to their identity as a doctor and to be seen as something other than a “mere housewife”, as a doctor with a mark of status in their social network. Memoona, a 32 year old woman doctor, was married immediately after she graduated. She was unable to practice since her husband did not allow her to work in a job. She acquiesced to save her marriage, since a divorce can bring great dishonor to a family, but being unable to practice was not easy, as she explained, “If you have spent almost all your life for one thing, being a doctor, it is not easy to just give it up. I did not want to waste all my

knowledge, everything that I worked for.” It was a source of constant tension for her, until one day her neighbor approached her to ask her opinion regarding a medical treatment. After that, providing care free of charge to her neighborhood has become a routine for her.

But more than that, to be able to heal is a profoundly satisfying and empowering experience for women; as Memoona explained to me, “To be able to help someone is addicting. If a sick person comes to you, and you are able to treat them, and make them right again, even if you are not paid for it. That feeling is something you can’t live without, if you have experienced it even once.”

Saima, for example, is a 42 year old medical graduate. Her husband worked as a public servant in the government of Pakistan, and was posted in different rural, under-developed areas of Pakistan during his job. Because of his frequent movement, it was not possible for Saima to participate in a regular job, but she was moved by the plight of women in areas where there were no women doctors, or trained medical personnel available to care of women patients. Rural health centers operated by public sector in Pakistan are often severely understaffed and under-funded. Eager to help, she started going to rural health centers in the area where her husband was posted. It was not possible for her to keep regular work hours because of her domestic responsibilities, but the staff at the health center called her whenever her expertise was needed. In a small community, her reputation spread and local women would often seek her advice, even outside the health center. Working informally in this fashion kept Saima motivated and looking out for opportunities of further education. Later, when their family finally settled in a city, Saima started her formal training for post-graduation. However, the hospital in



which she worked did not have a paid post available for post-graduate trainees. As Saima did not want to delay her education any further, she started her training, working again without pay. However, while her family supported and approved of her service (without pay) in the first instance, they were critical of her working in a hospital without pay, as Saima explained, “My family thinks that now that I am working, I should be paid, it should not be *baigar* (bonded slavery). But I see no difference, I was working then and I am working now. I am happy to use what I have learned. It is my *farz* (duty).”

Saima’s quote problematizes how employment and pay is often equated with work, and unpaid work or care is automatically devalued. Even though she did not receive pay for work (formally employed or not), the value of work for her was not derived from the monetary benefits it provided but from being able to do what she considered her duty. For many Pakistani doctors, it is empowering to use their knowledge for healing and helping, and engage in continuous education, even if that work is not formally paid. More importantly, this subjectivity emanates from a notion of medical practice that defies the binaries of productive/nonproductive and work/non-work. Their ideal *work* is not participation in the paid labor force, the production of capital, or increasing purchasing power and household income as a cog in a capitalist economy. Rather, it is a purposeful activity that results in a continuous practice of care on the individual level and social responsibility and service on the macro-social level.

I must stress here that I am not underplaying the importance of economic security for individual empowerment. But I do want to highlight the complex relationship of this informal work with paid work and socioeconomic class. Every doctor regardless of their social status is expected to provide care, and women doctors practice informally

regardless of their employment situation and socioeconomic status. Their conception of working as a doctor is not limited to being employed, or working at a socially defined, public space of clinic. The work of “doctoring,” as they defined it, is the ethics of continuous work/care that takes place in every aspect of their social life, paid or not, inside hospitals or at home. Being a doctor is part of their identity, not just a paid job done in the confines of a specified space and time.

On the other hand, continuous engagement in informal work did sometimes result in a transition to paid work when conditions demanded it. For example, Faiza, a 45 year old medical graduate, had practiced informally in her community for a number of years when her husband was suddenly laid off. Without any other source of income, Faiza was forced to look for jobs in medical institutions. However, she had not maintained her registration with the Pakistan Medical and Dental Council and it was not possible for her to renew her license without engaging in “continuous medical education” by attending a requisite number of medical conferences and lectures. This was difficult for her to manage with her school-age children and an ailing mother-in-law to care for, and the financial costs involved. Instead of looking for formal employment, she decided to simply start charging for her services. She put up a small sign in her drawing room, advertising her nominal consultation fees. Since she had already built a great deal of trust in her community, and because her services were much cheaper and more approachable for patients than formal clinics, she was able to sustain her family through a period of hardship.

### **In/visibility and its Tradeoffs**

These examples cited above are indicative of many arenas of medical work that often remain invisible, and it is informative to delve further in the politics of visibility in medical work. We “see” work only through some context specific indicators, by a predetermined and prerequisite change in state of affairs, level of activity, or a finished product. These indicators are a product of a certain organizational ideology and social context, and thus become a site of contestation in a visibility/invisibility matrix (Star and Strauss 1999). The visible medical work, hence, is not simply indicated by healed patients, or the alleviation of suffering or improvement of wellbeing. It is “seen” through symbolic placeholders of medical work: the number of patients seen at a specific clinical location in a specific time, the number of treatments ordered, the number of surgeries, the number of employed doctors, nurses and staff, and so on. These indicators are abstracted and disembodied from the actual state of work (its producer, consumer or the space where work is done), which means that in increasingly abstracted medical work, dimensions of care become either invisible or are subsumed in the “shadow work” (Illich 1980) of hospitals that is assumed and taken for granted by both patients and health management. The Pakistani state, for example, “sees” legitimate medical work through the number of doctors registered with the Pakistan Medical and Dental Council. This number, however, has little association with actual medical practice going on, as I discuss above. Formally trained doctors may be practicing medicine in alternative settings and may not have a current medical license. Doctors with current medical license may not be involved directly in the work of healing (that is, their practice of medicine is non-clinical for example working in the insurance industry or as hospital managers). Making these

alternative practices visible (through this research for example) makes it possible to better understand the contribution of women doctors to Pakistan's health economy.

“Visibility”, however, is a double edged sword. In the matrix of visibility/invisibility, neither can be proclaimed a priori inherently good or bad, desirable or undesirable, and each has its own context-specific consequences. The boundary between them is a constantly negotiated process. Increasing abstraction, routinization and standardization of medical work make it more visible, and previously invisible and silenced work of care may find its voice, but at the expense of certain tradeoffs. This includes losing the personal discretion that informal medical workers enjoy, and increasing surveillance of their work by the state and medical profession. Increasing visibility (through registration and standardization, for example) also increases the burden of documentation, is time-consuming and raises monetary costs. “Invisibility”, on the other hand, allows freedom from surveillance and control. Since this particular type of doctoring is done outside clinical contexts, it has the potential to destabilize and subvert bio-political technologies of power that operate through the control of medical care.

Since such doctors work outside state control, they can also informally provide care in cases where its provision is prohibited socially, culturally or legally. One of Jahan's regular patients, for example, is her neighbor, Sara. One day, she called Jahan and was sobbing. Her husband had sex with her without her consent (Pakistani laws do not recognize marital rape). He was abusive and Sara was afraid that she may get pregnant. The morning after birth control (or plan B as it is called) was not available in Pakistan at that time. But Jahan knew that morning after pills just contain a different

amount of hormones also present in birth control pills. She calculated and sent over the required dosage of drugs. Later on, Sara asked Jahan about long term options of birth control. Her husband was against practicing birth control for religious reasons, but Sara did not want any more children. She could not go to a gynecologist either since it would have raised her husband's suspicions. Jahan suggested an injectable drug that is efficacious for a couple of years, and would be undetectable by her husband. Sara could not buy it on her own as she did not drive and she was always accompanied by her husband or her mother-in-law on all shopping trips. So, Jahan bought it, and during a neighborly visit administered it to Sara.

Control of women's bodies and reproductive rights is an important aspect of the bio-political state, and it is of particular significance in the context of Pakistan where multiple social, political and religious discourses overlap to discipline and govern women's bodies. Pakistan's state laws allow women's access to various forms of birth control, though abortion is illegal (and a criminal offense) unless the mother's life is threatened. Many people consider abortion and birth control un-Islamic, making it difficult for women to access proper reproductive health care. Structures of patriarchy like restrictions on mobility (especially the taboos associated with travelling unaccompanied) and economic dependence further hamper women's autonomy over their bodies. Woman doctors who work outside of clinical settings provide an invisible yet persistent resistance to this forms of control and subjection, decoupling bio-political control from medical care.

## **Towards a More Caring Medical Work?**

In this chapter, I have attempted to provide an alternative understanding of medical practice in order to explicate the interrelationship between the visible and invisible areas of work. Although these alternative sites of medical practice are common in Pakistan, the work done here, despite its technical nature, similarity to clinical work, and economic importance is not recognized as medical work or practice. It might be because this work is weaved inexorably with other social relations, it is offered and sought spontaneously and remuneration for this work is not expected and may even be considered repugnant, all of which goes on to highlight the contextual nature of how medical work is identified. I must mention here that this informal practice of medicine is not specific to any gender. Both men and women doctors engage in it to varying extent, but there are important differences. Men doctors are almost always likely to be employed, and their altruistic work usually takes place within an organizational setting, either as free clinics or by waiving fees for poor patients. More importantly, their volunteer work is almost always supplemental to their economically productive, visible, paid work. In contrast, women doctors who engage in informal medical care do so outside formal contexts of employment and provide health care without any expectation of pay. Therefore, it remain socially invisible. Although this work is empowering for women doctors, and important for the communities and social networks in which they are embedded, the lack of recognition means their work remains invisible to the state, prompting narratives of women doctors wasting national resources. As I discuss above, I am not advocating making all forms of medical work visible, as strategic invisibility, especially the discretion and freedom that it involves, may even be desired, especially in

medical work where doctors prefer to take a holistic view of their patients. However, one must be cognizant of the political implications inherent in the abstracted indicators that result in a specific social organization of work and the areas of invisibility they create.

The continuum of in/visibility in medicine *outside* the clinical boundaries in turn forces us to reexamine the nature of medical work *inside* the confines of the clinic.

Although the care work and emotion work involved in healing processes is a constant area of renegotiating the boundary of work/care in clinical settings, the occupational boundaries of medical work (and its status and power) remain fairly stable. On the other hand, demands of the health economy often result in practices of medicine that continue to muddy the waters (Allen 2000; 2004; Timmons and Tanner 2004). The work of nurse practitioners in the United States and the United Kingdom, or nurse-led practices in New Zealand, for example overlap with and share many aspects of work done by doctors (Fitzgerald and Teal 2004). Even though these workers provide a level of care as good as doctors, since their work is unrecognized as medical practice, steep differentials in pay, status, and autonomy remain (Horrocks, Anderson and Salisbury 2002). Perhaps re-organizing medical practices, and re-negotiating the boundaries of medical work would provide a better way for not only making the invisible medical work more visible but also lead to a more egalitarian health care provision system.

## CHAPTER 10

### WORK AND CARE: EXPLORING THE CARE LABOR IN PUBLIC AND PRIVATE

“Why do you think women in Pakistan find it so hard to pursue a job?” I asked Hanif one evening. Hanif, a bearded old man and father of three women doctors, all of whom have given up their career as doctors, took some time to answer my question. “I think it is because women in our region have never worked. We don’t know as a society how to deal with it.” It was surprising since women in Pakistan have always worked, both inside their homes and outside of them. Hanif hails from the upper region of Punjab, famous for its fertile land, and wheat and rice fields. His family, for several generations, has owned farmland in north Punjab, growing rice and raising cattle. Hanif is the only one of his brothers who did not take up his family’s occupation, choosing to become an engineer instead. Women in his family took an equal part in farming activities.

Transferring young rice plants to paddies and cutting wheat in *baisakh* are coordinated events in which the whole family, women and children included, take part. It is almost hypnotic to watch them planting rice in muddy waters in neat rows. It is not uncommon to drive on rural roads in Punjab and see women picking vegetables, tending the fields, and participating in the harvest. It’s the women of the house who own the livestock, buffalos, goats and chickens. They feed them, milk them, churn butter, and sell surplus ghee and eggs. Hanif’s mother had used this surplus income to pay his college fees when his father refused to do so. It seems a little strange that these activities do not count as working. “No, that was not work.” Hanif tries to explain to me what seems so obvious to him, “You see, they were caring for their family, not for someone else. That is part of their duty. It is *not work*.”



The second scene takes place in a different setting. It is a busy cross-section in the center of downtown Lahore, blocked by protesting doctors. They are sitting in the middle of the road in their white coats and stethoscope draped around their shoulders, universal symbols of their profession. These doctors, mostly young trainees and members of Young Doctors Association (YDA) are protesting their low salaries and unfair hiring and promotion policies. They are holding slogans like “Injustice to the saviors is injustice to the people,” and “Stop economic and financial murder of the saviors of the humanity.” Along with this protest, doctors are also striking in hospitals across Punjab, refusing to see the patients in out-patient departments. Patients, many of whom traveled across cities to get care, are congregating outside the deserted hospital buildings and they are holding a protest of their own. This has been an on and off scene in Pakistan in the past ten years or so, with doctors periodically going on strike to demand better salaries and service structure. This situation has resulted in various standoffs between government and YDA, with many doctors suspended from their job and imprisoned. Government officials insist that doctors have a duty to serve: they were trained by the state to provide services to the people, and doctors’ refusal to provide care is playing with the lives of people, against the esteem of their profession. A high court of justice listening to appeals against the strikes remarked that doctors had taken an oath to provide care, an oath which the strike violates (The Tribune 2012). The public seems to agree. On social media, newspapers, and television, doctors are portrayed as self-interested hypocrites who are slandering the status of medical care and increasing the plight of patients by going on strike (The News 2016; The Tribune 2011). The general consensus is against the doctors: medical care is

not like other waged jobs. Caring for patients is a vocation and a duty that cannot be denied, it is *not work*.

These two scenes cannot be more different: one is a silent, uncontested understanding that a woman caring and working for her family does not count as work, the other is a public protest against the devaluation of public health care. Yet, the theme that links these activities is same: Both the domestic and medical labor are activities that are motivated by the ethical responsibility to serve, and as the stories above indicate, both of them are not considered work but care.

Work as a concept perhaps remained the most elusive aspect of my fieldwork. The two examples that I quoted above highlight the complexity that underlies the categorization of various human activities as work and care: These activities seem very different on the outset, one is domestic labor and care provided within the circle of kinship and family, the other is a (somewhat under) paid care work done as formal employment. And yet, both of them are considered part of care, a categorization that renders these activities invisible, unproductive, or taken for granted. The problem here is the complex interlinking of different activities across various areas of living, and the changing social meaning and value attached to these activities based on the identity of the worker and the area of life in which they are performed (Glucksmann 1995). This begs the question: Why do some activities come to be counted as work, and others, by extension, not work? What is the value of activities that are not considered work, and the people who perform these activities? These are the questions that I explore in this chapter, specifically by juxtaposing two areas of women doctors' lives, their domestic labor and their medical labor.

To that end, the discussion is arranged as follows. First, I briefly discuss how waged labor as productive work has become the organizational principal of the social life in capitalist societies and activities that are classified as non-productive or care become invisible. I juxtapose two areas of care, home and public health, to explicate how the gendered division of work simultaneously compels women's household labor and makes it invisible as unproductive. I then explore medical work in public hospitals to show how doctors have to cope with the cultural expectation to provide care despite the difficult circumstances of their work. Finally, I discuss how using the ideal of economic value in capitalist economies leads to the devaluation and exploitation of care labor.

### **A Brief History of Working and Caring**

Let me begin then by tracing the history of “work” or “job”. The concept of waged work, job or career remains the central point in the capitalist economic systems of today. It is the basic source through which capital is distributed. Work is how people get access to status and move across class boundaries, the primary vehicle to access the basic necessities of life like food, shelter and clothing. Raising children as subjects of a work ethic, ready to participate in careers better than their parents is the gold standard of parenting (Weeks 2011, 6). Making people ready to work again, making them “productive citizens” is the professed goal of physical and psychological therapies, mental health institutions, welfare and development programs, and prison systems (Glazer 1993, 33; Macarov 1980, 12). Compulsion or desirability of work is not just an economic necessity. Working is becoming a subject of a liberal capitalist political economy, and thus a prerequisite for full citizenship (Seidman 1991, 315). Working is how individual desires and life goals are expressed, and how these desires are then co-

opted into something else entirely: not personal satisfaction, individual wealth, or social welfare, but reaffirming the social ideal of work through a lifetime of hard labor, and producing and inserting another generation of perfect subject-workers in the political economy. To problematize work, is then not just problematizing the economic aspects of it, but also the social structures produced and reaffirmed through it.

The kind of work one does and one's status have always been intertwined, though the status and value of paid work has varied in various cultures and at different times. Ancient Greeks and Romans considered working for pay or under someone's orders a mark of low status. In Europe, until the late eighteenth century, waged work was considered a mark of having no social standing in the society (Illich 1980; Arendt 1998 [1958], 83). It was only the concurrent development of the Protestant work ethic – desirability of work as an end in itself, devotion to waged work and its centrality in life – and the distinction between the private sphere of reproduction, and the public sphere of productive work, through which waged work become equated with work (Weber 2003; Fraser 1989) . It was only the development of the Protestant work ethic, through which devotion to work became an end in itself, and waged work became central in the organization in social life. In industrial societies, the distinction between the private sphere of reproduction, and the public sphere of productive work means that participation in paid work is not just a necessity, it is how individuals are transformed into citizens of the neoliberal society.

More importantly, the category of work is defined against its “other”, the rather broad category which for the purpose of this discussion I am choosing to call “care”. The labor under this umbrella is more elusive, difficult to theorize. These are the activities

which Arendt (1998[1958]) labels as “labor”, the activities one does out of necessity, which are “prescribed by the biological process of living organism and the end of its ‘toils and troubles’ come only with the death of organism” (98). These are the unproductive “menial tasks and services [that] generally perish in the instant of their performance and seldom leave any value or trace behind them” (Smith 1776, 295). This is the area of living which is euphemized as “life” when we speak of work-life conflict, or work life balance. These are the activities we do as part of caring for, and caring about others: as part of domestic labor done inside the home and as reproductive labor that is involved in continuing the existence of our species. This is the emotional and affective labor that is done as an invisible part of paid care work (Folbre 1995; Hochschild 2003), formally or informally, by healing the sick as nurses and doctors (as I show above), by mothering other’s people children as day care workers and nannies, and to help with domestic work as maids etc. These are also the activities that are mentioned in footnotes, or crammed in the last lines of acknowledgments in academic books and articles. This is the labor rendered invisible or removed to the domestic sphere; taken for granted that they will be done either by one self, and if not by women, unpaid or low paid, low class or low caste workers (Foucault 1986a; 1986b; Katzman 1981).

Underlying the dichotomy of work and care is the theory of self that is isolated, prior to its connection to others and its activities, which is purposive, directive, and acts on its own motivation. This is one reason why questions of agency, autonomy and choice have become central to the agenda of social and critical theory (Sandel 1982). Under this perspective, work is what is done in the masculine public realm, by an autonomous, instrumentally rational person usually as means to a financial end. Participation in waged

work, productive labor, legal rights and formal duties hence became associated with masculinity, while unwaged caring work, reproductive labor, and familial relations are degraded to the category of care, and women to a justifiably dependent class (see Fraser 1989 for a critique). Classifying activities as work and care then not just organizes labor, it also organizes and classifies those who perform these activities.

Although the labor that falls under the umbrella of care is varied and complex, it shares two important aspects. First, it is gendered: these non-work activities across the world are overwhelmingly performed by women. Women spend more time than men across the world caring for others, in volunteering, in caring occupations and doing domestic work (Waerness 1984). Indeed, the gender roles in patriarchal societies (men as breadwinners and women as care givers) are based on this division of labor (Folbre and Bittman 2004). Women's burden of caring (particularly unpaid caring) also explains their occupational segregation and their economic dependence. Second, these activities are almost always undervalued (England and Folbre 1999). The majority of the work that falls under this category is either unpaid (like domestic work or caring for children) or underpaid. Since the majority of the caring labor is done by women, the sexism in the labor market leads to undervaluation of their work. Moreover, as the majority of the recipients of the caring labor are unable to pay for it (the infirm, the elderly and the children), and caring produces public goods (not tangible individual profits), the immediate market value of care is almost impossible to estimate (England, Budig and Folbre 2002). Still, as I discuss below, using the example of domestic labor in Pakistan's family system, distribution of care is central to the organization of family structure in

Pakistani society and forms the basis of gendered hierarchies which women doctors encounter in their everyday life.

### **Caring at Home: Domestic Labor**

Saba's care-giving shift begins at five in the morning every day. She wakes up to the sound of an alarm that she fastidiously sets every night. She quietly tip-toes out of the room where her husband and her two children are still sleeping. She begins by starting the tea in the kitchen. Her mother-in-law is awake by this time (she spends most of her late night offering prayers *tahajjud*), and she eats a light snack with tea early in the morning before turning in for a snooze. After serving her, Saba irons her husband's clothes, polishes his shoes and lays out everything (including socks, underwear, a belt and a tie). Then she makes breakfast and packs lunches for her children and her husband before going to wake them up. Once everyone is ready, she drops off her children at school. Then she returns home to let in the maid who does most of the cleaning and washing, while she starts the day's curry for lunch. During rest of the day, she will cook curries and fresh roti for lunch, make afternoon tea and dinner, pick her children from school, help them with homework, pay the bills and pick up the groceries.

Saba is a 36 year old doctor, a graduate of Allama Iqbal Medical College, who is not currently employed. This is a normal day's routine for her, and she is not alone. Most of my participants, whether they work in paid employment or not, did the majority of the domestic work in their homes. "Nobody told me to leave my career, I think very few in-laws would say it directly, but they want me to finish the work at home first," as Saba told me. Married immediately after graduation, Saba was excited to start a new life. She was (and still is) passionate about working as a doctor. She did not broach the subject of

“work” during her marriage negotiations, as she explained, “I asked my parents and they told me that I can work this out with my husband after I get married, making demands like this might spook a good proposal, so I let it go. Anyways, it is not like we women get a lot of say in our marriages.” She decided to give it a little time before deciding whether to work as a doctor. A break after a lifetime of studying hard could not hurt, after all, and she decided to approach the subject with her husband once they had established some sort of a relationship. One month after her marriage, her mother-in-law asked her to “cook *kheer* (sweet rice pudding),” a ritual that symbolizes the initiation of a new daughter-in-law in the labor force of domestic work. Her mother-in-law assumed a more managerial position after that. She still dictated what was cooked and how much, what groceries were bought and served out the food during the meal, but it was now Saba’s duty to actually do the bulk of the domestic work.

Despite these domestic responsibilities, Saba did not give up on her dream of working as doctor. She kept trying to make time, to manage the work, but her attempts only increased her workload. She thought if she could ask her maid to make the bread (roti) she could cook curries in the evening, and get a job in the morning. Her mother-in-law simply refused, saying they were not going to eat the bread made by some maid’s hand and reheated, or yesterday’s curry. Her mother-in-law had kept the tradition of serving hot food straight from the stove alive for past twenty years, and there was no way this tradition was getting changed. Saba’s attempt to negotiate the household work created a huge furor, and her mother-in-law threatened to send her to her home if she did not “straightened up and work *seedhi trah kam na kiya*.” Fearing the shame it would bring to her parents, Saba gave up the idea of having a job.



There is no question that women across the world do more household work than men. Surveys of Australian households suggest that women averaged 23 hours per week of housework while men averaged 11 hours (Bittman 1992). A similar survey from the United States show that husbands contribute an average of 13 hours to housework while women contributed 18 hours per week (Sayer 2005). In Pakistan, women spend an average of 33 hours per week on house hold work and care duties, men spend average of 3 hours per week on the same activities. Women (much more than men) carryout the caring activities: cleaning, cooking, caring for children and looking after guests. The only household chore towards which men contribute is shopping (again reaffirming cultural taboos on the mobility of women).<sup>57</sup> Hence, every year Pakistani women spend two extra months of twenty four hour days on household and care. More importantly, this differential seems to increase in urban areas, where the majority of my participants lived and worked (for details see Appendix D). Saba's story is a look inside these two extra months of doing not-work compared to husbands. Even though these activities are important in sustaining social well-being, the capabilities of human beings, and producing the supply of labor required for a capitalist economy, they remain invisible and undervalued since they are unpaid and taken for granted.

There is also no doubt that most of this work is done out of love and care for the family. Caring for one's children is one of the most rewarding and fulfilling acts of love. Women that I interviewed invariably articulated their domestic duties in terms of love

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<sup>57</sup> The data obtained from Time Use Survey of Pakistan, 2007, available at the website of Bureau Statistics of Pakistan, <http://www.pbs.gov.pk/content/time-use-survey-2007>

and care they felt towards their family. Faria, a woman doctor, reflected on why she chose to reduce her work hours to spend more time with her family, “I know that I will probably earn less, but if I do not teach my children to be better human beings, who else will?” Faiza, another woman doctor, agreed, “Even if I find the most competent maids, their care cannot replace what I can do for my children.” This love and ultimate responsibility to provide care becomes one of the critical driving factors behind women’s domestic labor.

But as Saba’s story indicates, love is not the only motivation behind caring labor. In Pakistani multigenerational households, household labor is almost industrialized. New workers are acquired by bringing in new daughters-in-law, who enter the workplace of the home like a low level employee. Their labor is conscripted to produce and raise (ideally male) children who can add to the family’s earnings. They even get vacation time in the form of regular visits to their parents’ home where they are not expected to work, and maternity leave (*chilla*) which they spend in their natal home (*maika*). In the life cycle of women in patrilocal families, initial dispossession is offset by gaining power later in the life over subservient daughters-in-law, the only supply of workers women control. Patrilocal families effectively become an organization that manages and dispenses care, with older women usually in managerial positions controlling the distribution of domestic work, and younger women becoming the labor supply. Women thus have a stake in maintaining patriarchy in order to gain status as mothers later in their lives, a reason why the gendered distribution of labor in Pakistani households remains largely unchallenged (for a detailed discussion, see Kandiyoti 1988).

In patrilocal families of Pakistan, the distribution of labor, and who works for whom, forms the basis of social relationships within the family, and the deference and status that is coded through these relationships. Women as workers in this supply chain of care have very little say in whom they care for and how much. Saima, a young doctor described how after marriage, her mother-in-law told her to forget her parents and forbade her to call them and ask about them. Once Saima took on domestic duties, her mother-in-law dismissed the maid that previously helped with the housework, saying that now that a daughter-in-law is here to work, the expense of a maid was unnecessary. Huma, another young doctor, described that her usual housework after marriage also includes serving food to her twenty something sister and brother-in-law in their rooms, cleaning up their rooms and doing their laundry. Sajida, a gynecologist, similarly told me that she used to help her parents by occasionally giving them money out of her salary. When her mother-in-law found out, it angered her so much that Sajida had to stop.

More importantly women's narratives exemplify the frustration they felt providing care under duress, and the simultaneous moral responsibility they feel towards the recipients of this care. Nazia, a 34 year old unemployed doctor, described how her daily responsibilities not only include household chores but also oiling her mother-in-law's hair every night and massaging her legs. She reflected on her responsibilities, "If some night I forget to do it, or I am too tired, my in-laws and my husband quickly remind me how important it is to care for one's parents, how it is a religious duty. Sometimes I want to remind my husband that they are his parents, not mine. And he does not lift a finger for them." When I asked her why she continued to care for her parents-in-law, she said, "because even though I get tired doing this work, they are old and no one else is going to

care for them except me.” Roma, another doctor who juggles a career in gynecology with her household duties, described how she woke up every day before dawn so she could complete cooking before she came to work, and made *rotis* when she went back, “I requested many times to my in-laws to allow me to hire a maid, so she can make *rotis* or help with cooking. I am usually so tired after my shift end, but they do not allow it, because they think bread must be made by the hands of a woman in the house.”

Shaheena, another doctor, not only cared for her quadriplegic mother-in-law but also looked after the children of her sister-in-law. She explained how conflicted she felt about this care, “Sometimes I do not think it is really my job to do everything alone, but I am the one who lives with her (mother-in-law). My husband has a job and he does not work around home. So it becomes my responsibility.”

The compulsion to provide care is further intensified by the gendered division of labor in the household, and the patrilocal family structure that I described above. Because of this labor arrangement, it is considered women’s duty to provide care, their primary responsibility. Riffat, mother-in-law to a woman doctor, explained, “If my daughter-in-law has a job and works for her own happiness, the real work of a woman is still at her home.” Hussain, a doctor, explained that after marriage he expected his wife to care not just for him but also for his family, “I think it is part of our tradition that we take care of elders like they did it for us.” Men, on the other hand, are socialized since childhood to not participate in caring labor, since it is unmanly to do women’s work. In Pakistan, the work one is expected to do is part of “doing gender.” Doing feminine work (of caring in home) is what makes one a woman. This gendered construction of work is so strong that a man helping his wife or doing household work is shamed by saying that he has turned

womanly (*zenana*). Saliha, a medical specialist, for example told me that when she started her job, her husband started helping her in dressing up their children for school, and making up his bed. Even this small gesture did not go unnoticed. Her mother-in-law proudly told her that she never allowed her son to fold a sheet, and now after marriage, he has become *zun-mureed* (a wife follower). His husband immediately stopped helping her. Fazeela another doctor described the hectic routine of caring for her three small children and mother-in-law. When I asked her if her husband helped at all, she replied sardonically, “If I left a stove on by mistake, and the whole house burned down, my husband will not get up to turn it off.”

Because of this gendered construction of care, women struggled under the obligation to provide care, which they felt was taken for granted and expected, but never appreciated. Raheela, a woman doctor, for example told me about her household work, “Everyone expects me do everything perfectly, the house should be spotless, the meal should be always home cooked and delicious, and the children should never get sick and have the perfect scores in the school. And no one ever helps with any of it. But then if something is missing, a shirt is not perfectly ironed, or a bed is left unmade, they are quick to point out where you failed.” Her response is reminiscent of Arendt’s description of heroic labors, where the fight to keep up with the necessities of life is as relentless and merciless as the biological process of life itself (Arendt 1998, 98-101).

Raheela’s response perfectly illustrates the dilemma of women who struggle under the rigid structures of household care. This predicament is even greater for those women who, like my participants, are also expected to contribute to waged work because of their profession. Because of the gendered construction of care, they are expected to

shoulder the full burden of household labor. But in capitalist economies, it is the waged work that is considered more important for the society. While the provision of care is expected from women, this aspect of their life is rendered invisible as unproductive. The obligation to care at home combined with the difficulty to manage housework with the demands of a career is also one of the major reasons why many of the women doctors decide to forgo their career. This decision is especially poignant in the case of women doctors because they are expected to provide care both in the private and public sphere of work. Women are thus pulled by the opposing demands of capitalist ideology: To work in the public sphere to be productive (and hence to be recognized as autonomous, agentic individuals), and to do the “non-productive” care work in the private sphere (and hence fulfill their responsibility of love and care).

### **Caring at Work: Public Health Care**

Multiple perspectives of women and their families highlight some important aspects of caring labor done at home. While these activities are important for the economy, and for the families and recipients of care, within the family structure of Pakistan, these activities are often taken for granted. While this is easier to understand within the context of domestic labor, the undervaluation of care also extends to the caring labor done in the form of paid employment. The medical labor of Pakistani doctors in public hospitals is an example of caring labor, different from domestic work in the sense that is paid, and done in the public sphere, but still undervalued. I should note here that dimensions of care and work overlap in all aspects of medical work (Yates-Doer 2012). I have specifically chosen the example of public health care because, unlike private medical work, it does not produce surplus value. Its only value is for its beneficiaries:

mostly lower class people who receive the assistance needed to survive (and may be to continue generating capital as workers themselves). Using Arendt's analogy, public health care is like the housework of state.

Let me begin with the story of Aminah, a medical resident working in a public hospital of Punjab. Aminah's second shift begins at 8 pm in the Emergency Unit of Afridi Hospital. It is a building set apart from other hospital departments, a self-functioning unit in itself. Unlike a hospital in the United States, there is no triage room. Triage here is simple: The left side is the surgical unit and if you have a bleeding wound that is where you go; everyone else goes to right side, the medical unit. If later on, a "medical" patient needs a surgical procedure (for example, a belly ache is diagnosed as appendicitis), he or she is simply moved across the room. Another difference immediately notable is the absence of a waiting area, patients simply walk up to doctors and explain their problems. There is also no stack of insurance forms or history to be filled, no patient is ever refused even when his or her problem is not an emergency, and patients receive free medicine when they are being treated and when they are discharged. The cost that the patient pays is ten rupees, or less than one US cent, which is required to get the "*purchi*", an entrance token.

Pakistan spends less than 3 percent of its Gross National Product (GDP) on health related expenditures, around US\$36 per person. In comparison, the United States and United Kingdom spend around 8% of their GDP on health: the United States around US\$9,403, and United Kingdom US\$3,935 per person (World Health Organization 2016). After a visit to an emergency unit in Afridi hospital, it is not difficult to understand how this system of socialized health care (where health care is provided free

or at a nominal cost by means of legal regulation or subsidies by the government) works with nominal spending by the government. It works on the shoulders of health care providers, doctors, nurses, and paramedical staff that run Pakistan's hospitals, who are underpaid and have to work under substandard conditions, as I discuss below. When I visited Aminah in an emergency unit, it was what people of Lahore affectionately call "gastro season," a time between July and September when the monsoon starts and Punjab is hit with a gastroenteritis epidemic. Patients filled the emergency ward, two or sometimes three on a bed. Around 20 or 30 of them were standing around the doctors' table, each with their tokens in hand, clamoring to be seen. Doctors work in quiet efficiency: there is no time for all the preliminary formalities, or a place to sit for either the patient or the doctor. The formalities of privacy or confidentiality have little meaning in this crowded room. Aminah quickly assesses every patient, asks questions and takes their history as she examines them. Then she either writes out a prescription if the patient does not need admission, or she starts an admissions chart with instructions for nurses and asks the patient to find a bed to lay down.

In most Western countries, patient admissions are usually subject to hospital capacities, and hospitals refuse care and redirect patients when they are full. In Pakistan, public hospitals and doctors patients are never refused to be seen or denied admission. Aminah reflected on how doctors decided the admissions and treatment:

We are taught clinical criteria for admission in various diseases. We keep them in mind but they do not always work in Pakistan. I see a patient who has diarrhea but clinically does not require admission. I can send her home with instructions to hydrate, but I also have to consider that the patient may not follow my instruction because of illiteracy, and then she lands in an emergency room tomorrow in much worse shape than today. So if I am even slightly suspicious, I keep the patient here.



This is not just the case with emergency units, doctors that I interviewed in other departments similarly had to account for the social contexts of their patients and Pakistan's health economy, and compensate by modifying their care work. In Pakistan's hospitals, doctors not only perform their designated medical duties (diagnosing, treating and performing medical procedures), but also do work which cannot be articulated within the vocabulary of medical work. In some cases, it includes assessing which patients are in too much distress to share their bed with someone else, and which can be treated on make shift gurneys and beds fashioned from hospital seats. In other cases, it meant maintaining a roster of all medical students and doctors with their blood groups, so they can be called to donate blood for patients (and in many occasions, doctors had to donate the blood themselves when no match was found). It also includes buying food for patients' attendants who could not afford it out of their own pocket. Dr. Huma, a pathologist, told me that the doctors in her department pooled money to buy the chemicals required to perform microscopic examinations, since the government had not approved funds for this in years. Another doctor mentioned a similar fund maintained to pay for the treatment and procedures not covered by the hospital. These activities are not part of a doctor's job per se, but doctors have to do this labor as part of caring for their patients.

Interestingly, even though doctors identified these activities very clearly, they did not consider them "work." As doctors, they considered themselves more than just workers, and their conception of healing went beyond the narrow definition of medical work. They considered it their duty, part of their service and moral commitment to provide care in any way they could manage. Hina, another doctor working in pediatrics, explained, "We have to adjust patients, and manage somehow. If someone is in pain, or

sick, you cannot turn them away. You cannot be responsible for anyone's death.”

Punjab's major tertiary care public hospitals receive patients from all over the province, and these patients are often those who were denied treatment, or referred to the provincial capital because their disease has already advanced. Doctors in these hospitals are often their last resort. Both doctors and patients are aware of this ethical responsibility. Imran, a surgeon, explained, “When a patient walk through this door, he knows that this is it, there is no other option. And I know that no one else can help, I have to help this person, or he suffers.” Sana, a medical specialist, concurred, “When patients come to us, they have been refused treatment in many places, or worse, maltreated. They are hopeless and at their last tether. We have to do what we can.”

This knowledge of being ultimately responsible is similar to women's experience of providing care in their families. This consciousness generates an irresistible ethical pressure on the doctors (just as it did for the women caring for their families) to provide care for their patients in any way they can. This situation is buttressed by the cultural conceptions of the work of healing in Pakistan. As I discussed in the previous chapter, the profession of medicine has a different cultural construction in Pakistan from most Western countries. Unlike Western countries, where “doctoring” is considered “work”, a highly valued and well paid work at that, in Pakistan, medicine is classified as “care.” As doctors' narratives mentioned above illustrate, when talking about their profession, doctors also used the vocabulary of fulfilling their duty in providing care, rather than just doing their job. Doctors in Pakistan are similarly not considered workers. Instead they considered to be messiahs (*maseeha*): selfless saviors whose moral responsibility is to serve humanity. This is reflected in the structure of medical work in public hospitals,

where medical duties do not have a fixed description, and expand to include everything from diagnosing and treating to providing beds and managing hospital resources.

It is interesting because in most studies of medical work, regulation and oversight is a critical issue. Narrowly defining what exactly doctors and nurses are supposed to do as part of their job description not only interferes with the discretion of medical workers but also renders invisible the emotional and caring aspect of their job (Allen 2014). Here, the opposite is true, but a lack of regulation does not mean that caring aspect of medical work is recognized; rather, every aspect of the job is considered part of medical care and hence not only becomes invisible in the machinery of health care but also taken for granted.

This lack of recognition and a cultural imperative to care creates an ideal situation in which Pakistani doctors' care and work can be exploited. For one, doctors (and other health workers) in Pakistan's public hospitals have been historically underpaid. Doctors who are just starting their career, particularly young residents who are training for their post-graduation, are particularly vulnerable, as for the sake of completing their training, they work without pay for several years. Husna, a young resident, for example described her job structure:

We doctors work hard for five years in college, and after that five more years for specialization training. By the time that is done, an average doctor is more than 30 years old. He has a family for which he has to provide, maybe he has sister that he has to support, or old parents. But he will be paid only Rs. 40,000 (about 400 US\$) per month. The peon that sits outside this office gets more pay than that.

Moreover, unlike other public employees, there are no fixed policies for hiring and promoting doctors in the public sector. As a result, many of them remain stuck in low

paying ranks throughout their career. There is also a strong culture of overwork (or *over-care*) in medical work, which means doctors are encouraged, even required by their supervisors to go beyond their duties, to work late even after their shift has ended, to extend their services by providing continuous care. A senior doctor reflected on the expectation of work in medicine, “We tell students in the first years what is expected of them, this profession is demanding, it is not like working in an office where you can close shop. Here you stay as long as it is required.” Another surgeon spoke of the nature of caring itself that almost always overlapped with the medical work, and thus compelled doctors to care/work, “I cannot go home and sleep if I do not know the patient I just operated on is well. This is what I expect from my trainees as well. I expect them to stay with patients till they are stable.”

It would seem from these narratives that this care is provided voluntarily, out of the sense of duty or moral obligation, but the frustration of doctors with this system is evident in their responses. Saliha, a young resident, expressed her anger not just at the decrepit public health care but also at the expectation from doctors to manage and cover the shortfall, “If their dialysis machine is out of order, it is the doctor’s fault. If there are fewer beds in ward, this is the doctor’s fault. If there is no ventilator available, or lab testing is slow, everything is the doctor’s fault. There is no use explaining that this is not our job.” Hiba, another doctor, was equally frustrated by the expectation of going above and beyond the duty for the “VIP’s” as she called them. “Whenever a relative or family member of a public official, journalist, or a hospital manager is admitted, they expect us to be subservient to them, to take extra care of them,” she said. “We are doctors, why should we make any difference in how we treat people.” Faizan, a surgeon who left his

job in the public hospital because of this frustration, explained, “We did our best as doctors, but we are humans, and we control very few things in the hospital management. But then if anything goes wrong, every politician, every journalist, uses us doctors to score points. They find it easier to just stroll in here and disrespect us than doing their job. I could take it no more. I left my job.”

### **Refusing to Care**

In the preceding discussion, I have discussed how the care giver felt compelled to provide services because of their ethical moral responsibility. Is it at all possible to refuse to care? As the narratives of women’s household work suggests, negotiating household labor is a nearly impossible endeavor. Refusing to provide care, or do domestic duties can and does have violent consequences for women. Many women doctors recounted stories of physical abuse at the hands of their husbands and their in-laws when they tried to change the pattern of household work. Shaheena, a woman doctor recounted how her parents-in-law beat her and locked her in the bathroom when she refused to leave her job. Fahmeeda, another woman doctor, spoke of beatings she received from her husband while her mother-in-law watched and encouraged her son. Hina, a young doctor, reported how her mother-in-law tore her diplomas when Hina decided that she wanted to start a job. More common was the mental abuse and acts of violence that are difficult to articulate in Pakistan’s society. The social stigma attached with leaving the relations of care—to walk out on one’s family or to get divorced—dictated that most women lived with the abuse and the duties of care.

However, the case of caring labor in public health is different: Frustrated with the condition of their work, and the devaluation of care in public hospitals, publically

employed Pakistani doctors finally started a public movement to get better pay and transparency in hiring. Using the only service they could leverage, they stopped providing care. This movement, Young Doctors' Association, was started by doctors (most of which were in junior ranks of medical profession, or still under training) in 2008 when a woman doctor was harassed by a patient's attendants. During the one-year period (2011 – 2012), doctors in public hospitals of Punjab called for strikes and protests more than ten times. The longest strike in June 2012 lasted two weeks during which outpatient departments in all public hospitals of Punjab remained closed (Chaudhry 2012). The major demands of the doctors were better salaries, service structure and provision of security in hospitals (Abid 2012). As a result of these strikes, patients across the Punjab (particularly those who could not afford private care) were deprived of health care. Even though doctors continued to work in emergency rooms and provide critical care, patients suffered as their non-critical illnesses were not treated (The News 2016). One newspaper reported as many as 22 fatalities as a result of doctors' strikes (Tribune 2011).

The state's response to this protest was swift and severe. Police reports were filed against doctors and they were arrested and threatened with jail time. Their meetings and assemblies were forcefully and violently dispersed. When protests and sit-ins continued, the government used an emergency legislative measure (Section 144) which bans any assembly of people (even peaceful ones) to stop the protests. Instead of providing a service structure, or raising the salary for doctors, the government used the rhetoric of "the moral responsibility of doctors to provide care" to force them to work. In a state run advertisement campaign in Pakistan's newspapers, government appealed to the parents of the doctors to side with the state, stop their children from strikes and return to their job of

“serving the endangered humanity.” Another advertisement asked the people to decide if doctors should be allowed to play with the lives of people (Figure 13). Yet another advertisement used a picture of a sick baby, and asked “How is this being a savior? (Figure 14). Wards are closed, patients are dying and doctors on strike.” Dr. Faizan, one of the participants of this movement, explained his frustration, “People respect us as the saviors and the healers, but they do not want to pay us. They want us to be literally like the Jesus Christ, poor, barefooted and suffering. But when we say that we, too, have children that we need to feed, and bills that we have to pay, and we need money for our work, then this whole image comes crashing down.” Despite the difficulties faced by the doctors, there is no move towards increased salary or improving service structure. As struggle of the doctors goes on and has spread to other provinces, protests and strikes have become a routine in Pakistan’s public hospitals. Whether it will lead to a recognition of the worthiness of care, or drastic change in the medical profession, remains to be seen.

# یہ سلسلہ کہاں رُکے گا؟

دہشت گردی، سیلاب، لوڈ شیڈنگ اور وفاقی حکومت کی نااہلی اور بدعنوانیوں پر مبنی پالیسیوں کے نتیجے میں درپیش بے شمار مالی مشکلات کے باوجود حکومت پنجاب نے ڈاکٹروں کی تنخواہوں اور مراعات میں گزشتہ

بیس اضافے کے لئے اربوں روپے کے پیسے کا اعلان کیا۔  
اس پیسے کے بعد کیا ڈاکٹروں کو اپنی تنخواہوں میں مزید اضافے کے لئے ہڑتال پر جانے اور لاکھوں غریب مریضوں کی جانوں سے کھیلنے کی اجازت دی جاسکتی ہے؟

## فیصلہ عوام خود کریں حقائق یہ ہیں

جون 2011 سے پہلے اور جولائی 2011 کے بعد ڈاکٹروں کی تنخواہوں کا موازنہ


نمبر شمار	سکیل/کلیگری	جون 2011	جولائی 2011 ہیلتھ پروفیشنل ایسوسی ایشن کے بعد
1	BS-17	40 ہزار سے 59 ہزار روپے	60 ہزار سے 76 ہزار روپے
2	BS-18 (نان ٹیچنگ)	51 ہزار سے 1 لاکھ 26 ہزار روپے	61 ہزار سے 1 لاکھ 36 ہزار روپے
3	BS-18 (ٹیچنگ)	95 ہزار سے 1 لاکھ 65 ہزار روپے	1 لاکھ 50 ہزار سے 1 لاکھ 75 ہزار روپے
4	BS-19 (نان ٹیچنگ)	1 لاکھ 4 ہزار سے 1 لاکھ 89 ہزار روپے	1 لاکھ 14 ہزار سے 1 لاکھ 99 ہزار روپے
5	BS-20 (ٹیچنگ)	1 لاکھ 9 ہزار سے 2 لاکھ 19 ہزار روپے	1 لاکھ 19 ہزار سے 2 لاکھ 29 ہزار روپے

اضافی اخراجات: ساڑھے چار ارب روپے سالانہ سے زیادہ

محکمہ صحت  حکومت پنجاب

Figure 13. Where will this Stop? An Advertisement Placed by Punjab Government in Daily Express (An Urdu Newspaper) On June 28, 2012






**یہ کیسی مسیحائی ہے؟**

• وارڈ بند  
• مریض جاں بلب اور  
• ڈاکٹر ہڑتال پر...

**یہ ہڑتال قطعاً بلا جواز ہے کیونکہ**

حقائق یہ ہیں کہ

- پنجاب میں سرکاری ڈاکٹروں کو پاکستان کے تمام صوبوں سے زیادہ تنخواہیں دی جا رہی ہیں۔
- ڈاکٹر کی ڈگری حاصل کر کے گریڈ 17 حاصل کرنے والا ایک نوجوان کسی دوسرے محکمے میں یہی گریڈ حاصل کرنے والے اپنے دوسرے نوجوان ساتھیوں سے دوگنا زیادہ معاوضہ حاصل کرتا ہے۔
- حکومت پنجاب نے ڈاکٹروں کی تنخواہوں اور مراعات میں گزشتہ برس اضافے کے لئے اربوں روپے کے پیسے کا اعلان کیا۔

محکمہ صحت  حکومت پنجاب

SPL-9130

Figure 14. How is it being a Savior? An Advertisement Placed by Punjab Government in Urdu Newspapers of Lahore, June 2012.

## **Value of Care Work**

The two examples that I discuss above show how the activities that have a strong component of caring are often degraded, devalued, and underpaid or not paid. Both domestic labor and medical work in public hospitals are similar in this respect, and women working at homes or doctors working in public hospitals feel responsible and morally compelled to provide care. For them, their work as doctors and home makers is satisfying because it allows them to relate to other people and to help them. These are also the activities that have no obvious material or financial value. They do not produce any tangible product that has an exchange value. While the importance of domestic labor and public health care is obvious for the functioning of economy, neither is directly “productive.” As a result, these activities are taken for granted, exploited and rendered invisible.

Thus far I have discussed what the consequences are of classifying activities as work and care. The question that remains is why certain activities are considered valuable as work, and others are devalued as care. To answer this, we have to understand what the relative value (or values) assigned to each activity is and why. “Value” as a social construct describes what is desirable in a society. Hence, for an activity to have value means that it is worth doing, and that it leads to a socially desirable end: riches, prestige, honor, satisfaction. To understand then why some forms of labor are important and valuable for a society, and other are not, is to understand the political philosophy of that society, for things and activities take on value only in a given system of hierarchies and categories (Graeber 2001, 55).

As Marx's value theory of labor suggests, in the capitalist "market" system of value, where the labor is commodified, the only value that is legitimately recognized is the economic value (Marx 1867), where "work" produces tangible, lasting products that can be exchanged, calculated and measured. In this system "only certain forms of labor (waged labor or at best, labor that contributes to producing marketable commodities) produce value in the first place" (Graeber 2013, 224). Hence the obsession of modern society with the various measurements, data sets and yardstick with which we can compare the "value" of everything. This is the only form of activities that is socially recognized: in symbolical form as productive "work" and in material form by being economically valued and monetarily compensated. That is the reason why the activities that have no immediately recognizable material benefit (like household work or the socialized public health care system) are often taken for granted or undervalued in capitalist economies (Graeber 2001, 65). This is also why socialist feminist scholars insist that household work also has an economic value, an effort that has led to the global movement to recognize various forms of caring labor, to determine their financial value and the inclusion of the value of this labor in SNA (system of national accounts) of a country's economy (for example Folbre 1995; 2006). Participation in paid work and the production of capital thus becomes a regulatory ideal in the capitalist economy: it is seen as an important step towards empowerment of women, the gold standard of individual and social development, and the ideal of a "good life."

However, in the categorization scheme of labor, "work" is not intelligible without its opposite category of what I have labelled as care. It is because "work" has no inherent value of its own, as it always gets its value in relation to (and by de-valuing) care. As I

discussed above, the value of caring labor for its recipients and its workers does not lie in its economic potential, it is described in different terms. The caring labor is done out of love, or the ethical and moral responsibility one feels towards the people to which one is connected, or out of an overwhelming sense of duty. These are the activities that do not produce any difference in the value (Smith 1776, 295), even though they are done for moral, ethical and emotional values (plural). This “concrete medium of value realization” (Turner, as quoted in Graeber 2013, 225), tangible and comparable economic worth in terms of money versus intangible and incomparable “love,” “fun,” “happiness,” or “care”) is what differentiates work from the other areas of life that fall under the category of care. As the examples that I discussed above show, the activities motivated by these intangible values are objectified and exploited: rendered invisible in the private sphere of home, and underpaid and undervalued in the public sphere of work.

### **Conclusion**

“It is the characteristic right of the masters to create value.” (Nietzsche 1966, Beyond Good and Evil)

In the discussion above, I have discussed the contrast between two areas of human activities, the productive “work”, and the activities that fall under its other: affective, caring and emotional labor that is done in homes and as part of formal employment. I have also shown how in a capitalist, patriarchal system of values, only economically productive activities are recognized as the ideal of “work”, while activities motivated by intangible values are exploited and undervalued. It is precisely this categorization, their differential valuations and their gendered nature that underlies the occupational segregation of men and women, where women are pushed out of the waged work, under-

represented in the upper ranks and hierarchies of paid work and remain concentrated in the areas of work which require affective or caring labor.

Is there a way to move beyond this dichotomy of work and care? There are no simple answers to this question. One way is what I mentioned above, to recognize the economic value of care. However, this perspective as I show above, legitimizes the “market” ideology where money is the only yardstick through which value of an activity can be measured, and as the example of doctors protesting their unfair salaries indicate, the alternative values of love and care are simply conscripted to and exploited in the project of generating capital. Here, the ideal of “good life” becomes a lifetime of work, a reason why the culture of over-work permeates the modern workplaces (Holland 2008). The economic value (rather than a means to some higher end) becomes an end in itself, the only moral and ethical principal worth following. Instead of working to *live*, to enjoy, have fun, care for others, we live, rest, and provide care so we can work and produce economic value.

Similarly, anyone who decides to define a different form of good life in terms of personal relationships and care is deemed unproductive, just as the women doctors of Pakistan are labelled who decide to leave their career for their families. The so-called unproductivity of these women is not because the activities they do are not important, it is because of this underlying ideology of productive work.

More importantly, money or economic worth is not the only system of values that forms the basis of human relations. As Sahlins points out “self is not the sole end of an individual’s existence any more than it is the exclusive means.” (2013, 168). Caring for children, helping the elderly, or healing patients are activities whose value cannot and

most definitely should not be expressed only in monetary or economic terms. The beneficiaries of these activities are people who may not be able to pay for it, like children, but need this care to live their lives. Using economic worth as the only benchmark for productivity means that these areas of labor are not considered worth investing in (Folbre 2006) either individually or collectively. This is why it was difficult to introduce health care reforms in the United States, and the fate of the Affordable Care Act still hang in balance. Using the ideal of efficiency and cost effectiveness particularly in the delivery of health care is not a morally neutral endeavor. It essentially prioritizes economic value over other values of life. It means that medical care is increasingly becoming standardized like work to speed it up, to cut its costs and to offload it to home-based care provided by family. It is doubtful that this results in the provision of better health care and the crisis faced by National Health Service (NHS) in the United Kingdom after budget cuts (Aziz 2017), or the public health care crisis in Europe (Karanikolos et al. 2013) are examples where aiming for cost effectiveness can go horribly wrong. Similarly, increasing regulation simultaneously increases the workload for doctors (Woolhandler and Himmelstein 1991) and further contributes to the invisibility of care labor in clinical settings (Fitzgerald 2008).

On the other hand, idealizing the caring and loving aspect of labor also becomes problematic. As the examples of domestic labor and medical care show, these values become the very basis on which the caring labor is exacted from its workers. The argument that love should be its own reward becomes the reason why women are compelled to provide care in patrilocal, patriarchal family systems whether they like it or

not, and doctors are forced to work for unfair pay in public health institutions by any means necessary.

Perhaps a better way to evaluate activities is not to determine their economic value but to understand the meaning these activities have for those involved, and what kind of social reality this labor produces. The value that we attribute to various activities is a result of our individual projects and thus is subject to contestation and negotiation. We must thus resist both against the hegemony of monetary value and the exploitation of care labor. Using the words of Graeber (2001, 103), instead of determining the monetary value of caring labor, or extolling the value of love, perhaps we must decide, either individually or collectively, what activities we consider worth doing and what things make life worth living.

## CHAPTER 11

### CONCLUSION

*Jehra bolay, O'hoai bo'a kholay.*

The one who points out the need for something to be done, must also assume the responsibility to do it. A Punjabi Proverb.

The descriptions in the media of the women doctors of Pakistan, or indeed about women anywhere in the world who struggle between various demands on their time, their work and their bodies, are often couched in a narrative of choice. The aim of research about working women often is to demystify their choices, what led them to choose different paths and how these choices can be influenced. The discussion in this dissertation however problematizes this narrative of choice by pointing out the broader social structures that still confine women's choices. Although increasing number of women in the medical field may be seen as indicative of a broader change in Pakistani society (that women are able to exert their own personal choices in their educational and career decision making), unpacking the value of the medical profession for women problematizes this view. The preference of medical profession for women in Pakistan is not because women are freer to choose their own educational and career pathways, or to be more independent as professional women. Instead, it results from multiple overlapping social and cultural factors. Medicine has become more acceptable as a profession for women because its particular structure of work reaffirms and upholds the ideal image of a Pakistani woman: One that is modern on the outside but chaste and domesticated inside; comfortable in the public space of paid employment but never too invested in her career to forgo her domestic duties; and whose education makes her a more capable mother and



a suitable partner for her spouse. Similarly, as I discussed in Chapter 4, this particular image of a woman doctor is also the reason why doctors are sought after as potential spouses. Their professional education is seen as a “status symbol,” a mark of their class and social status. As Wendy Brown (2015b) points out, this is indicative of the underlying market reason and rationality permeating the Pakistani society, a process which she calls economization, where education is not sought after because of its expected return through increased income, or even provision of care to the society, but because it increases the worth of an individual in the marriage market.

However, the structure of care in Pakistan’s familial system is such that the position and social status of women changes drastically after marriage. After marriage, a Pakistani woman enters her marital home as a more or less disenfranchised individual. Her domestic labor is conscripted in the hierarchy of work within the extended family unit while she simultaneously loses the access to the support structure provided by her own natal family. On the other hand, professional education itself produces a certain kind of subject: professionals that are trained to work, and I use “work” here to mean the socially constructed, economically valued, productive work of participation in a paid job. Women doctors are hence caught betwixt the divergent demands of their society: An economy of care in the private sphere of home and an economy of care in the public sphere of medical career. These demands on women also produce subjectivities that are similarly conflicted and divided between desires to fulfill the criteria and norms of their familial roles (to be an ideal mother, wife, daughter-in-law, and so on) while simultaneously achieving the success that is demanded of professional women in their careers. Similarly, even though the majority of Pakistani women still do not participate in

paid work, women's employment ratio is increasing steadily, particularly in urban areas (The World Bank 2014a). In this milieu, two sites of gender inequity however, have remained largely unchanged: the gendered distribution of labor within the household and the social policies that are aimed towards ensuring an equitable educational and career economy for women. Pakistani women thus face two very divergent sets of expectations: On one hand is the powerful cultural imperative to always put their homes before their careers, on the other hand is the culture of their profession where an environment of overwork means that every doctor is compelled to show complete commitment to their career or risk being seen as non-serious or unprofessional.

Moreover, as I discuss in detail in Section 2, the organizational culture of medical workplaces is such that women doctors have less access to organizational resources, advice and mentorship. Though an increasing number of women in the recent graduates from medical colleges has created a momentum, and number of women in registered medical practitioners has been steadily increasing in past years (as Figure 20, Appendix A indicates), the majority of upper level positions in the organizational hierarchies are still predominantly occupied by men (Hargens and Long (2002) call this demographic change organizational inertia). Hence, men generally have more control than women over organizational resources and power within the workplaces. Specifically in the case of Pakistan, the norms of purdah and modesty dictate that both women and men develop a deep seated gendered habitus, where cross-gender interactions are governed by a myriad of cultural and religious precepts. This interactional order is further reinforced by the material structure of public spaces (including workplaces), where spaces for men and women are generally segregated. However, success in career and education demands

building extensive informal networks and because of the cultural and religious restrictions on women's mobility and personal interactions, women often face a greater disadvantage in this regard.

Organizational policies and laws also play an important role in creating a more equitable workplace for women. Although women are given protection against overt discrimination in pay through Pakistan's Constitution, and multiple policies have been enacted to ensure women's participation in workforce, in reality most of these policies are not implemented. Provision of childcare facilities, maternal and family leave policies, and flexible work and career structure are especially important for the recruitment and retention of women in workplaces. As I discuss in Chapter 8, women face much more difficulty in accessing these rights within workplace. Even though women's presence is increasing in the workplaces, Pakistani workplaces seem to be stuck in an anachronist time where policy structure is still based on the ideal image of a masculine worker who is unencumbered by the social demands of care or biological demands of reproduction.

Part of the reason for this administrative burden is the fact that workplaces themselves are not the gender neutral structures they are purported to be. For one, as feminist researchers in organizations point out, the bureaucratic hierarchies, distribution of power, pay and rewards within these hierarchies, and organizational processes are inherently gendered. Moreover, the people who populate these organizations themselves are products of their particular social and cultural context. As the experiences of women of policy structure in workplaces indicate, the attitudes of the frontline bureaucrats who are tasked with implementing the policies play an important role in curtailing women's access to these resources. Specifically, in the case of a medical career, a lack of

transparency in medical training, hiring and promotions disproportionality affects women's progress through their career and work

The role of policy design in this regard cannot be ignored. In Pakistan's popular and political discourses, women's work outside their homes is either construed as a danger to the traditions of Pakistani society, or rendered invisible. Therefore, politicians and law makers are generally reluctant to peruse the policies and laws that facilitate women's work, and should any such legislation reach the parliament, it usually faces stiff opposition from various religious parties and leaders (laws against domestic abuse and against workplace harassment, for example, faced severe conservative opposition). Similarly, the needs of women workers are often not taken into account when new policies and laws are implemented. As the case of central induction policy shows,<sup>58</sup> ignoring women workers and failing to account for cultural context in policy design can drastically increase the administrative burden on women doctors.

The structure of work in medicine and the particular organizational culture in medical workplaces also adds to women doctors' difficulty. The structure of post-graduation training in Pakistan has changed little since Pakistan's inception and still follows the pattern set by British medical educators. During this training, young doctors are pushed to over-work to demonstrate their complete commitment and devotion to work. For young women this training is particularly difficult to follow, since the initial, most time consuming and labor intensive part of the medical training coincides with the

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<sup>58</sup> A policy created to produce a centralized system of post-graduate medical training, through which post-graduate medical training can be posted anywhere in the province, discussed in Chapter 8.

time when they are starting their families. As a result, fewer women choose to specialize after they graduate (as the Figure 20, Appendix A indicates), and most of these specialists tend to remain in “women friendly” specialties. The effect of this horizontal underrepresentation is tremendous for the health delivery system of Pakistan. Due to an increasingly saturated market in urban areas of Pakistan and poor working conditions in the public sector, more and more doctors are choosing to emigrate rather than work in Pakistan. This trend, combined with the attrition of women doctors from the workforce, means that there is severe shortage of doctors particularly in the rural areas of Pakistan and in several specialties.

Perhaps the most important aspect of women doctors’ case is the theme of work that is woven throughout their stories. In the neoliberal, capitalist economy of today, “work” (read: paid job) is only way to be recognized as an “individual,” a full-fledged, productive and valued member of the society. Only those who participate in performatively masculine work in this gendered division of labor are those who have access to the rights, freedoms and autonomy that come with being a subject of neoliberal society. This capitalist evaluation and division of labor has overlapped with patriarchal social structures in Pakistani society to produce a particular social assemblage in which caring labor, or care work (whether in public sphere or in private) has become an invisible and undervalued (yet indispensable) part of the human world.

In *Undoing Demos*, Wendy Brown (2015b, 104) has posed a provoking question, “What happens when the indispensably necessary ethos and labors highlighted by McClosky, Tronto and England are both disqualified and trod underfoot as *homo oeconomicus* becomes the real in every sense of the world?” In more than one way, the

experiences of women doctors provide a glimpse into this reality. When generation of capital becomes the governing principle of work-life, social organization and family life, women are doubly penalized. They must either conform completely to the demands of this particular society (become “workers”) or become the invisible care-givers that hold the social fabric together by caring for sick, young, old, infirm and poor (all those who are deemed to have no value under this rationality).

The case of women doctors is particularly poignant because they are dual care-givers, and they struggle under the dual responsibilities of this labor. Increasing capitalist rationality has gradually transformed social relationships within Pakistani families to intensify the division of labor between a private market of care and a public market of work. Woman’s domestic, social and relational labor is still praised and expected as a feminine virtue, as part of honor, or as family’s *izzat* (respect), but this labor does not provide her with autonomy or rights. It just enmeshes her further within the social-economic relations that make her and her labor invisible. This logic, extended to the public sphere, leads to public disinvestment in social welfare, family friendly policies and socialized healthcare, and women doctors are again on the wrong end of this particular equation. They have to work in increasingly difficult work conditions, where simultaneously their labor is undervalued and they remain invisible and underrepresented in the organizational structure.

In this milieu, women doctors’ informal practice of medicine is a point of radical departure. In this particular form of labor, the boundaries of working and caring overlap in a way that is not possible in the over-regulated health care systems in the majority of the Western countries. As I discuss in Chapter 9, not only is this form of care/work

important for the women themselves and their communities, it also has the potential to defy the bio-political control exerted by the state and families on women's bodies.

Throughout this dissertation, I have tried to highlight the dialogical nature of human reality, to point out that "restrictions of social structure" is only one side of the story. Society itself is created by the overlapping interactions between multiple projects or "serious games" as Ortner (2006) would call them, of individual social agents in various social positions. It is within these relational spaces that negotiation and contestation between individual projects takes place. An important condition of adopting this dialectical approach is not just to describe what things are in a particular point of time (as I have done) but also, in Graeber's words (2001, 254), to imagine, "What they have the potential to become." In other words, not just to describe what ethnographic reality is, but also to point out the political possibility of different realities. This is the issue that I want to discuss in these concluding pages.

### **Problem of Choice**

"Ideally, I think I should be allowed to work if I want to, and not work if I do not want to" – Bina, 39 year old woman doctor on choice

During fieldwork, I asked my participants to indulge in a moment of utopian reverie, to describe where they see themselves in their version of an ideal world. Narratives in the media portray women as docile subjects who have internalized discourses about their place in their society, who lack commitment or impetus for a career and readily leave their profession to care for their families. Women doctors' responses, however, show that these women are far from what media or policy makers portray them to be. The majority of them draw equal inspiration from the two areas of

their work, their home and their profession. Even though they differ in their individual preferences and the decisions they make, a majority of them would ideally like to give time equally to their work, their homes and their families. Most of them spoke of a world where their salaries were more generous, where their husbands shared their house work, where the care and love that they offered to their families was equally valued and where they could spend more time with their families. While they value economic independence, most of them agree that work and care has a value beyond its economic potential. They see empowerment in helping their patients, in their ability to soothe people in their distress, to cure them when they are sick. They also see empowerment in caring and educating their families and children, the only avenue where a majority of them think a meaningful and long lasting change can be made. For them, participation in paid work is a choice that ideally they would like to make on their own terms, not because it is required of them as a duty as doctors and not because they owe their labor (domestic or otherwise) to anyone, either to the state or their families.

What can be done to change the cultural expectations regarding the women doctors' domestic responsibilities and paid work was a more difficult question to answer for my participants. Most women doctors agreed that the gendered distribution of labor at homes (and the attitudes of families regarding women's work in general) needs to be changed to make it easier for them to work. Most of them also agreed that this change is unlikely to happen, at least in their lifetimes. They were acutely cognizant of patriarchal structures in our society that create and perpetuate this gendered distribution of work. For example, Sara, a woman doctor reflecting on the differential expectations from women in Pakistan, said, "When a man comes home from work, he expects that he will put his feet



up and he will be served tea, but when a woman comes home, we expect her to make tea for everyone, and nothing will change until this expectation changes.” The only possibility of change women doctors saw was through education (or *tarbeat* as they called it), as Fahmeeda, a woman doctor explained, “We women prop up this system ourselves. Who stops men from going to the kitchen, or cleaning? We women do. We teach our sons that this work is feminine. And we will have to change it.”

Other women described how they have already started this change by subtly problematizing this division of labor in their homes, through their children. Zahida, a woman doctor, told me that she cannot ask her husband to help with the housework, because “it is difficult for a person to unlearn the training of a lifetime,” but she can do it through her children, “I ask my son to come with me to kitchen, I let him play with flour, make macaroni, add spices etc. So he does not grow up to be insecure about it.” This shows the value of domestic work. Women can use this devalued domain of domestic labor to create social change in ways people don’t anticipate by raising sons in certain ways to create change. Making this change is not always easy, since women also have to negotiate the more immediate family structures policing these gendered norms. Zahida’s mother-in-law, a woman with a traditional view of gender roles, does not agree with her and constantly forbids her grandson from coming to kitchen, asking him to play outside since “boys have no business being in the kitchen.” But Zahida persists in her efforts, though it is always a source of tension in their home. Saba, another woman doctor, told me that she makes it a point that her sons and daughters participate in all activities together. She told me, “It is difficult against all the messages children keep getting from

outside, other children or people telling them girls do not do that, or boys do not do that, but I hope that at least this way, my children will have a different perspective.”

Giddens (1984) explained how social structures change and evolve gradually in response to individual practices, a process he calls structuration. It is almost as if the women of Pakistan use structuration as a strategy for social change (rather than just an explanation of it). This is not just the case with the division of labor at home, women doctors’ practices exist in constant tension with the norms of gendered behavior expected of them, as I have discussed in various chapters. Hira, a woman doctor, was not allowed to join a co-educational medical college, and she went to an inferior, women’s only college. However, she in turn allowed her daughter to join a co-educational college despite the misgivings of her family, because as she told her family, “women are going to have to deal with men as doctors anyway, so it is better for them to have a training before they start a job.” Farah, another woman doctor, allowed her daughter to attend late-night socializing events and departmental parties so she does not miss out on networking, driving her to the avenues by herself to allay the fears of her family. And these strategies are to some extent paying off. Parveen, a mother of a women doctor encouraged and supported her daughter’s decision to join a specialty with very few women. Her family was unhappy with this decision, going even so far as to boycott her socially. But as she happily reported, “Now all of my disgruntled family members are my daughter’s patients. They congregate in my living room, and she checks them up one by one. Now they are happy that she is such a good doctor.”

Unlike the dogged tradition in Western philosophy of infinite individual beings in constant conflict with each other in the reckless pursuit of individual desires, these

actions by women doctors and their families are more indicative of “investment” in their reality, present and future. In case of Hira above for example, her “agency” is not defined by the (seemingly oppressive) decision to give in to her family’s norms of not joining a co-educational college. It is defined by the investment in social change by transforming the norms for her own daughter. It is also indicative of a desire and agency that is not articulated in individual terms, but which is entangled in its social structure. It is a desire to change that operates within the field of human relations. That is also partly why women doctors choose to accept the norms of arranged marriages (while remaining in simultaneous conflict with this norm), or make compromises on their career and family: their choices are not based on a worldview defined by their individual motivations, their actions have meaning and value only if they make sense in the system of relations in which they live. This may seem similar to what Scott (1985, 33) termed as everyday resistance with “implicit disavowal of public and symbolic goals. Where institutionalized politics is formal, overt, concerned with systematic, de jure change, everyday resistance is informal, often covert, and concerned largely with immediate, de facto gains.”

However, I would like to problematize this differentiation between public forms of resistance and private ones. As women doctors’ responses show, resistance is often opportunistic, an insidious practice that remains at constant odds with the strategies of domination. Political and overt resistance, compliance, tacit acceptance, negotiation and refusal are not distinct responses, but practices of a resistant, recalcitrant subjectivity that refuses to conform. Social change thus comes from marginal politics in the relational field: in the form of a co-operative husband, a supportive family or a daughter who is allowed to negotiate gender roles.

## **Policy Recommendations**

The next aspect of change that I want to discuss is more instrumental. I have discussed in the Chapter 8 that juridical power in the form of policies and legal changes is just one aspect of social structure, and the disciplinary power yielded by families, peers, colleagues and front-line workers is much more important in determining the policy experiences of women doctors. However, there are some changes that can be suggested to make workplaces more equitable. This is something that was discussed many times in detail with my participants, and in formulating these suggestions I have kept their responses in mind. Moreover, under-representation of women in STEM fields is a global challenge and many universities and institutions across the world have developed policies and laws to stop the attrition of women from STEM careers. I have also looked at this policy literature while making these suggestions. I should note however, that these recommendations are by no means exhaustive, and should be considered as an initial step towards the long journey towards equity in the medical profession for women doctors.

The first step in this regard is to identify on each level, not just in medical education, what kind of institutional climate is present for women doctors: whether there is equal representation of women; fair allocation of resources, salary, research support and social and material space between genders, and whether government and institutional policies reflect the problems identified by women. This requires in-depth research and data collection from employees and students so that their specific problems can be addressed. It also means keeping track of students during medical education through a dedicated postgraduate affairs office, establishing a feedback system through which students can give input in the curriculum design and education, provide their opinion of

the quality of teaching, and can report any experience of bias or discrimination. Through this, students should have access to appropriate career counselling, and their career progression should be tracked after graduation. Apart from this, institutional heads and deans should make it clear that the contributions of women as students and employees matter. It means having zero tolerance policies against discrimination and harassment, drawing attention to the status of women in each department and making the heads of departments responsible for what happens to women students and employees in their department. Similar measures have been taken at Harvard University and John Hopkins Departments of Medicine to improve the climate of their science, engineering and medical departments for women (Fried et al 1996).<sup>59</sup>

An important reason why women doctors' concerns are often not addressed in major policy changes is their lack of representation in the policy process. The newly implemented central induction policy<sup>60</sup> for example, will likely have serious repercussions for women doctors. However, no woman doctor was involved in designing this policy. At the time this dissertation was written, there was no woman heading any medical institution in Punjab, among the core team of Department of Specialized Health Care, or heading any professional medical organization (like Pakistan Medical and Dental Council). There is no professional association of women doctors to articulate their

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<sup>59</sup> The executive summary of the taskforce on Women in Science and Engineering (WISE), 2005. Available at [universitywomen.stanford.edu/reports/women-faculty.harvard.se.5.05.summary.pdf](http://universitywomen.stanford.edu/reports/women-faculty.harvard.se.5.05.summary.pdf)

<sup>60</sup> A policy structure implemented by Punjab Government for selection and posting of post-graduate trainings.

demands. This is a serious issue that needs to be addressed, and one way to ensure women doctors' representation is to make it necessary that there should be a minimum number of women doctors present in designing new health related policies and in all hiring and promotion committees. Moreover, instead of using policies like central induction, the need of underserved rural areas can be better served by providing monetary incentives for the doctors who are willing to work in rural areas, or making it a compulsory part of post-graduate training. These are the policy measures taken in the United States and Australia to counteract the shortage of physicians in underserved areas.



Figure 15. A doctor as Secretary of Health Department: A Banner Displayed by YDA outside a Public Hospital

The experience of sexism and gender bias in workplaces at the hands of co-workers, policy makers and front line bureaucrats with which women doctors interact are also an important determinant of the persistent inequity in workplaces (Watkins et al.

2006; Settles et al. 2006). The gendered segregation that I discussed in Chapter 6 is also the reason why women doctors feel isolated in the workplaces and do not have access to mentorship or advice. It is difficult to change these structures of modesty or purdah through state led initiatives, nor is it advisable since such actions by state are perceived as an infringement on personal freedom. However, one way to address this is to educate both men and women doctors in ethical workplace behavior. While doctors in Pakistan are taught about treating their patients ethically, they are not educated on how to interact with their peers. Another way is to institute mentorship programs early in the medical education which allow women doctors to build social connections and advice networks with their peers. In many universities across the United States, for example, graduate students and junior faculty are paired with a senior mentor to provide guidance and support (see Mark et al. 2001 for mentorship programs in academic medicine). This approach can be used in Pakistan's medical colleges, and it can be beneficial for senior faculty (who are kept abreast of the latest knowledge in the field), as well as junior students and faculty (who gain knowledge and information about the workings of the department).

The structure of post-graduation in Pakistan is based on the strength of advisor and advisee relationships, and women doctors who I interviewed often felt isolated, and reported receiving less advice and support from their supervisors (For importance of mentorship for women, see Noe 1988; Scandura and Ragins 1993). One way to remedy this is to make pedagogical training part of supervisor certification, and this training should include a strong gender bias component. Supervisors should also be encouraged to take on both men and women trainees, and trainees should provide extensive feedback

about their supervisors. Promotion and compensation of the advisors should be made (at least in part) subject to these reviews. Another problem with post-graduation training is lack of regulation. Many women doctors reported that it was their men colleagues who were often favored during teaching and practical training, and they have no way to report or complain since there is really no specific plan of teaching or training to be followed. While it is important to leave some discretionary powers with the supervisor – both students and teachers agreed that training has to be tailored to some extent to an individual doctor's future plans and past experience – it is also important to have a degree of transparency about training procedures and requirements, and allocation of research and training resources (for the effect of biases in resource allocation on research productivity see, Long and Fox 1995).

Finally, it is important to help women doctors integrate their career with their lives. Although some of the policy structures are already present for that (like day care centers and breast feeding provisions), these policies should be implemented more effectively. Instead of day-care centers, 24 hour care for children should be available since most doctors have to work on day as well as night shifts. Moreover, as I discussed in Chapter 8, using child care may not be possible for some families. Therefore in some cases, childcare scholarships should be provided to offset the cost of at home care. These facilities will help women and men doctors equally in combining work and care responsibilities.

Moreover, many universities and institutions across the world offer career and work flexibility for their workers with care responsibilities (including women with children). This policy is not available for Pakistani women doctors (or any other worker



in Pakistan's health institutions). As I discussed in Chapter 7, medical training is like a rigid pipeline with very little lateral mobility, and a fixed timeline, which is often difficult for women to follow. Women who have children during their training should be given an automatic extension on training deadlines. More importantly, flexible work policies should encourage remaining in work with reduced work hours, rather than taking breaks during training. This is because, at present, women doctors often take breaks during their career, or start late when their children are at least school age. As a result, they are under-represented in the upper ranks of the medical profession. Allowing women to reduce their work hours will result in fewer breaks in their resume, while simultaneously increasing the supply of practitioners in the health economy (A detailed discussion of flexible work structure and its importance of persistence of women, see Stone 2007).

Another way to increase women doctors' participation in work is to rethink how medical labor is organized in the medical profession, as I discussed in Chapter 9. Women doctors' unpaid medical work provides us a way to re-conceptualize medical labor that is not limited within the space of the clinic. I should note here that this is not possible for all specialties (for example the specialties which require hospital care) but in the majority of the rural areas of Pakistan, there are few doctors available even for primary health care. There are already initiatives that are using internet and mobile technologies to not only bring women doctors back into the workforce but also to provide health care in underserved areas. DoctHERs for example is one such initiative that creates a virtual market place where women doctors can access and treat patients remotely (Kim 2017). At various clinics operated by this initiative, patients are examined by nurses who convey their findings to a doctor, who in turn can remotely guide nurse to carry out further

treatment. Reimagining health care with fewer regulations and more personalized work structures will result in a more affordable health care and increase the participation of women doctors.

### **Limitations**

An important constraint of this research is that I have limited information about various social factors that overlap and intersect with gender to affect labor participation. I conducted my fieldwork in Lahore and interviewed doctors that were residing in Lahore during the period of research. I selected this location because as I mentioned in the methods section, the city is the second most populous in Pakistan and a major hub of medical education. I also selected this location because I had extensive contacts in the community of doctors here which allowed me to establish trust with my participants with relative ease.

However, in Pakistan, geographical location can significantly change the experiences of women doctors. Although I tried to interview women who were educated in other parts of the province (as the educational details of participants in Table 5, Appendix B indicate), the majority of my participants spent most of their careers in Lahore. Women working in other provinces where gendered norms vary significantly may have different experiences in the workplace. In Khyber Pakhtunkhwa for example the majority of population is of Pashtun or Afghan origin. In the particular tribal culture of this region, norms of honor are more closely observed, and women have much more restrictions on their mobility and participation in paid work. This province (and its neighboring federally administrated tribal areas) have also been greatly affected by the war on terror and subsequent militarization in the area. The rise of religious militias,

including the Taliban and their enforcement of patriarchal tribal laws in this area has severely curtailed the educational and career opportunities for women. As Figures 16 and 17, Appendix A indicate, the gender gap in medicine in this province is much greater than in any other part of Pakistan. Similarly, in Baluchistan another relatively less developed province of Pakistan, the population is sparse with few developed urban centers, so women have to travel long distances for higher education, adding further problems in their career. These differences also reflect in the distribution of medical educational resources in various provinces of Pakistan. Out of 101 recognized public and private medical colleges, 55 are in Punjab, 23 in Sindh, 17 in Khyber Pakhtunkhwa, 4 in Azad Jammu and Kashmir and only two are in Baluchistan.<sup>61</sup> As distribution of registered practitioners in various provinces (Figure 16 and 17, Appendix A) indicates, this unequal distribution of resources eventually translates into disparity in provision of health care.

Another particularly intriguing and interesting factor is that of class. However, all of the women doctors that I interviewed belong to the middle to upper class (perhaps because the medical profession is associated with significant status and economic mobility). The relative absence of women from working or lower socio-economic classes itself speaks to how important socio-economic class can be in determining access to educational facilities. This is an important aspect that this research does not cover sufficiently, since I focused primarily on the women who did manage to become doctors.

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<sup>61</sup> Data obtained from official website of Pakistan Medical and Dental Council, from the list of recognized medical colleges (available at <http://www.pmdc.org.pk/AboutUs/RecognizedMedicalDentalColleges/tabid/109/Default.aspx>)

However even within this small range, the intersection of class with gender and other social factors creates multiple differences which I have pointed out in relevant chapters.

Another limitation of this research is that I was unable to access all avenues of women doctors' paid work. Though I did include women who worked in public hospitals and private ones, and those who worked as entrepreneurs, a major employer of women doctors is Army Medical Corps in Pakistan. Even though I asked several doctors currently and formerly employed by Pakistan army, they refused to discuss the particulars of their service citing their service requirements. Including these women would have added to the richness and depth of this study since army has used some innovative ways to retain women doctors in workforce. For example, they recruit majority of their candidates through separate medical colleges and cadets are required to sign a contract beforehand which requires them to provide a specific period of service after graduation. Doctors are also allowed to appear in specialization exams only after a certain period of employment. Moreover, women who already have relatives in army (husband or father) are given preference in admission process. All of these policies are different from other public sector hospitals and it would have been extremely interesting to compare these two areas of work.

### **New Directions**

My research also highlights some important directions for future research about the women in Pakistan, particularly women working in STEM fields.

For one, this research focuses only on the experiences of women doctors in the medical profession, where women's participation has relative cultural acceptance (as I discussed in Chapter 5 and 6). However, women are still extremely under-represented in

other scientific fields, particularly engineering (which is considered “men’s work”) in Pakistan. Similarly, this research also indicates the importance of understanding the cultural context behind the occupational segregation of women in certain fields. Therefore, this line of inquiry should also be extended to women students and workers in other fields to understand their experiences in these extremely men-dominated educational institutions and organizations.

Similarly, as I discussed in the chapter on workplace relations, modern workplaces extend into virtual spaces and social media sites, and so do workplace relations. Although some considerations of *purdah* do seem to extend in virtual spaces (like gender segregated social media groups, since the common practice is for women observing the veil to use either a veiled picture of themselves or that of an inanimate object in their profiles), these spaces may hold potential for the subversion of gendered norms. However, in depth observation of interactions and conversational patterns in virtual spaces is needed to understand how *purdah* is “done” in these spaces, particularly through examining the professional and personal interactions in these virtual spaces.

Another difficulty that I encountered throughout this project, and which points to an important avenue of future research, is gathering extensive data on women doctors’ employment and career processes longitudinally. This data can be collected from a cohort of students serially over a period of time to understand how the demographics are changing within the medical profession. To this end, I am planning to continue this research by remaining in contact with my participants to see how their career progresses over the coming years. Serially collecting women doctors’ resumes or CVs over time to

see how their careers progress is one such approach that can be adopted (and for examples of this see, Gaughan 2009. Corley, Bozeman and Gaughan 2003)

Finally, there is another ongoing change in Pakistan's healthcare system: the uprising of young doctors against their work conditions, to demand better pay, more transparency and more autonomy in medical work. As I discussed in the last chapter, this movement has met with constant resistance from the state and the public, and over the years, has become increasingly violent. The incidences of violence against doctors by the state and by disgruntled patients have become increasingly common in past years. These incidences almost invariably result in immediate and vehement protests by the doctors increasing patients' suffering and deaths due to neglect. As I am writing these concluding words, young doctors have been on strike across Lahore for the past three days, a protest that started when police tried to arrest a doctor (and ended as a gesture of solidarity with victims when a blast rocked Lahore on February 23, 2017). The government is considering the proposal that young doctors' refusal to provide care should be considered an act of terrorism and prosecuted with the severest penalties. In a way, this movement represents the struggle to recognize the value of caring labor and tracing how it transforms Pakistan's health care (for better or for worse) can provide fascinating insights into the grass root movements and the public forms of resistance.

### **Speaking of Women**

In conclusion, let me return to the question of speaking about women's rights in Pakistan or articulating Pakistani women's perspectives of their social reality. In Pakistan this debate is inexorably linked with the post-colonial history of Pakistan. The first project of "emancipating" women in South Asia began at the hands of British colonizers

as white men's burden to save brown women from brown men (Spivak 1988). The "ideal" of this movement was the Western, middle class white woman, and the only logical desire possible for a feminine subject was to achieve the ideal of this status. Even though thoroughly critiqued by post-colonial scholars, this perspective still continues through discourses of development and modernity where a Pakistan woman is assumed to be oppressed if she does not want to challenge the structures of patriarchy, or does not want to participate in paid work, or to be economically independent. Worse still, her actions are construed as the desires of a subject who has internalized the structures of oppression and has become a willing participant in her own oppression. The feminist analytics thus constructed this figure of Pakistani woman as their own variant of alterity—a tradition bound, conformist, non-Western woman—who is an anathema to the feminist project of individual freedom and agency. Her actions cannot be explained without simultaneously apologizing for the indomitable social structures in which she is embedded. This is the analysis critiqued by the postcolonial scholars of feminism, who seek to dethrone the ideal of Western societies for the rest of the world. They assert that the agency and empowerment for women needs to be defined based on their own context and their experiences.

However, this view still does not leave room for Pakistani woman who articulates her desires in terms of her individual choice, who speaks against the structures of inequity perpetuated by patriarchy or challenges traditional norms. This is the woman who risks being labelled as Westernized by her society. Her choices are thought to be a proof of moral and social decline resulting from the onslaught of Western culture. Even when she speaks of autonomy and choice, she is denied agency because her actions are

construed as blind following of a Western rhetoric of rights, or using a Western construct to save women from their presumed oppressive culture.

These are also the difficulties that a researcher encounters when attempting to speak for Pakistani women (Charania 2014). While the post-colonial project of asserting difference is admirable and necessary, it fails to take into account the fact that ideas may originate in one space but they do not remain confined to it. While the ideology of universal human rights has its basis in Western, liberal thought, the ideas of individual freedom and choice has spread as a result of globalization. Many women, like Pakistan's women doctors, are not just aware of this rhetoric, they use it strategically to critique their own society. So how to speak for them without risking the age-old critique of false consciousness (De Lauretis 1990)? In many ways, an emancipated, empowered Muslim Pakistani women has become unthinkable in society as well as academic research. A Pakistani women has to occupy a subject position perpetually defined by negative: She cannot be content and happy in her traditional gender roles as this makes her a victim of patriarchy, or worse, a willing participant in her own oppression. She cannot speak of her individual choices and freedoms since she will be labelled Western by her society and subjugated to colonial discourses by theorists and condemned by both. Perhaps giving voice to this unthinkable can provide us a way to theorize possibilities of radical change for Pakistani women.

A requirement of looking forward is however to remain hopeful for the possibility of change. As the unfolding stories of Pakistani women show, every individual practice is a site of contestation and an avenue of change where identities, boundaries and restrictions are negotiated. In Foucault's words,



My optimism would consist rather in saying that so many things can be changed, fragile as they are, bound up more with circumstances than necessities, more arbitrary than self-evident, more a matter of complex, but temporary, historical circumstances than with inevitable anthropological constraints. (Foucault 1988, 156)

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APPENDIX A

EMPLOYMENT AND REGISTRATION PATTERNS OF DOCTORS IN PAKISTAN

Name of Institute	Medical Officers		Senior Registrar		Assistant Professor		Associate Professor		Professor		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
Lahore												
Allama Iqbal Medical College (AIMC)	0	0	0	0	22	40	9	22	7	23	38	85
Jinnah Hospital (attached to AIMC)	84	116	21	24	0	0	0	0	0	0	48	92
King Edward Medical University (KEMU)	0	0	0	2	31	47	11	20	6	23	48	92
Lady Aitchison Hospital (Attached to KEMU)	17	3	7	1	0	0	0	0	0	0	24	4
Lady Wellington Hospital (Attached to KEMU)	22	10	12	4	0	0	0	0	0	0	34	14
Mayo Hospital (Attached to KEMU)	80	85	12	31	0	0	0	0	0	0	115	261
Fatima Jinnah Medical College (FJMC)	0	0	0	0	21	9	9	4	9	9	39	22
Fatima Jinnah Medical University (FJMU)	0	0	0	0	6	3	3	2	2	1	11	6
Sir Ganga Ram Hospital (Attached to FJMC)	97	53	18	20	0	0	0	0	0	0	115	73
Lahore General Hospital	80	85	12	31	0	0	0	0	0	0	92	116
Pakistan Institute of Cardiology	10	66	1	9	0	14	0	7	0	3	11	99

Services Institute of Medical Sciences (SIMS)	0	0	0	0	13	35	11	15	10	21	34	71
Services Hospital (Attached to SIMS)	60	88	32	36	0	0	0	0	0	0	92	124
Punjab Institute of Mental Health	15	31	0	0	0	0	0	0	0	0	15	31
The Children Hospital and the institute of Child Health	68	82	21	16	21	25	10	8	4	5	124	136
Punjab Institute of Neuroscience	0	0	0	0	0	1	0	0	0	0	0	1
Post Graduate Medical Institute	0	27	1	5	17	30	6	13	7	13	31	88
Said Mitha Hospital	11	22	0	0	0	0	0	0	0	0	11	22
Mian Munshi DHG-1 Teaching Hospital	9	23	0	0	0	0	0	0	0	0	9	23
Institute of Public Health	4	6	0	0	1	2	0	1	2	0	7	9
300 Bedded Hospital Shahdara	30	43	2	3	0	1	0	1	0	0	32	48
Ameer Ud Din Medical College	0	1	0	0	0	0	0	0	0	0	0	1
Blood transfusion Services	1	2	0	0	0	0	0	0	0	0	1	2
College of Ophthalmology and Allied Vision Sciences	0	0	0	0	0	2	0	0	0	0	0	2

De-Montmorency College of Dentistry	0	0	0	0	6	5	0	3	0	2	6	10
Government Kot Khawaja Saeed Teaching Hospital	18	50	0	0	0	0	0	0	0	0	18	15
Government Mozang Teaching Hospital	3	5	0	0	0	0	0	0	0	0	3	5
Government Muhammad Nawaz Sharif Hospital, Yakki Gate	25	52	0	0	0	0	0	0	0	0	25	52
Health Department	0	0	4	11	0	1	0	1	0	0	4	13
Faisalabad												
Punjab Medical College	0	4	0	3	9	32	2	14	2	16	13	69
Dental Section, PMC and Allied Hospital	0	0	0	0	6	5	0	3	0	2	6	10
Allied Hospital	22	38	10	28	0	0	0	0	0	0	32	66
District Head Quarter Hospital	43	70	4	9	0	0	0	0	0	0	47	79
Faisalabad Institute of Cardiology	15	38	2	5	0	3	0	9	0	0	17	55
Government General Hospital Ghulam Muhammad Abad	8	14	0	0	0	0	0	0	0	0	8	14
Office of the Executive District Health Officer	0	0	0	1	0	0	0	0	0	0	0	1

Children Hospital	20	8	1	4	0	0	0	0	0	0	21	12
College of Paramedics	0	2	0	0	0	0	0	0	0	0	0	2
Rawalpindi												
Rawalpindi Medical College	2	0	8	15	26	28	4	8	5	16	45	67
District Head Quarter	20	24	6	6	0	0	0	0	0	0	26	30
Holy family Hospital	58	35	15	17	0	0	0	0	0	0	73	52
Benazir Bhutto Hospital	47	31	13	20	0	0	0	0	0	0	60	51
Rawalpindi Institute of Cardiology	22	21	4	5	0	5	0	1	0	1	26	33
Multan												
Chaudhry Pervaiz Ilahi Institute of Cardiology	15	54	5	15	1	11	0	7	0	3	21	90
Kidney Center	21	30	2	2	0	5	0	0	0	0	23	37
Nishtar Medical College	3	0	0	1	7	38	3	16	3	11	16	66
Nishtar Hospital	69	103	12	64	0	0	0	0	0	0	81	167
Nishtar Institute of Dentistry	0	0	0	2	5	6	0	1	0	0	5	9
The Children Hospital and Institute of Child Health	15	41	3	8	1	16	1	1	0	2	20	68
Gujrat												
Aziz Bhatti Shaheed Hospital	18	34	0	0	0	0	0	0	0	0	18	34
Sialkot												
Government Sardar Begum Teaching Hospital	5	4	0	0	0	0	0	0	0	0	5	4

Khwaja Muhammad Safdar Medical College	3	8	3	5	6	10	2	5	1	4	15	32
Allama Iqbal Memorial Hospital	21	18	0	3	0	0	0	0	0	0	21	21
Bahawalpur												
Quaid e Azam Medical College	3	3	2	13	17	37	3	22	3	24	28	99
Bahawalpur Victoria Hospital	48	94	11	46	0	1	0	0	0	0	59	141
Civil Hospital	57	43	7	8	0	0	0	0	0	0	64	51
Gujranwala												
Gujranwala Medical College	2	4	8	15	6	20	4	5	2	6	22	50
Wazirabad Institute of Cardiology	4	15	0	2	1	0	0	0	0	0	5	17
Sargodha												
District Head Quarter	31	23	0	0	0	0	0	0	0	0	31	23
Sahiwal												
Haji Abdul Qayyum Hospital	2	6	0	0	0	0	0	0	0	0	2	6
Sahiwal Medical College	2	3	0	4	5	17	3	10	1	3	11	37
Rahim Yar Khan												
Sheikh Zaid Medical College	1	1	7	21	7	40	0	7	0	6	15	75
Sheikh Zayed hospital	43	93	0	0	0	0	0	0	0	0	43	93
Dera Ghazi Khan												
Dera Ghazi Khan Medical college	5	0	0	2	6	12	1	11	0	3	12	28
Teaching Hospital	25	69	0	9	0	0	0	0	0	0	25	78



Table 2. Employment Data, Doctors in Tertiary Care Hospitals, Punjab, Pakistan, 2016\*\*

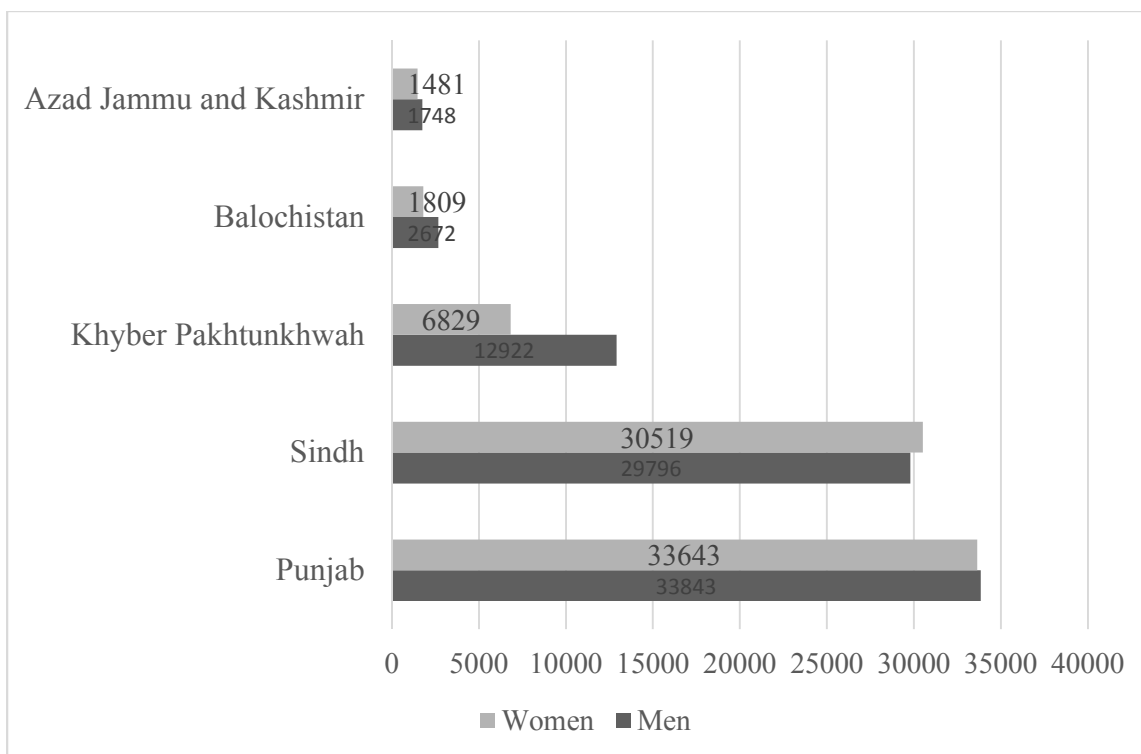


Figure 16. Gender-wise Distribution of Doctors in Provinces of Pakistan\*

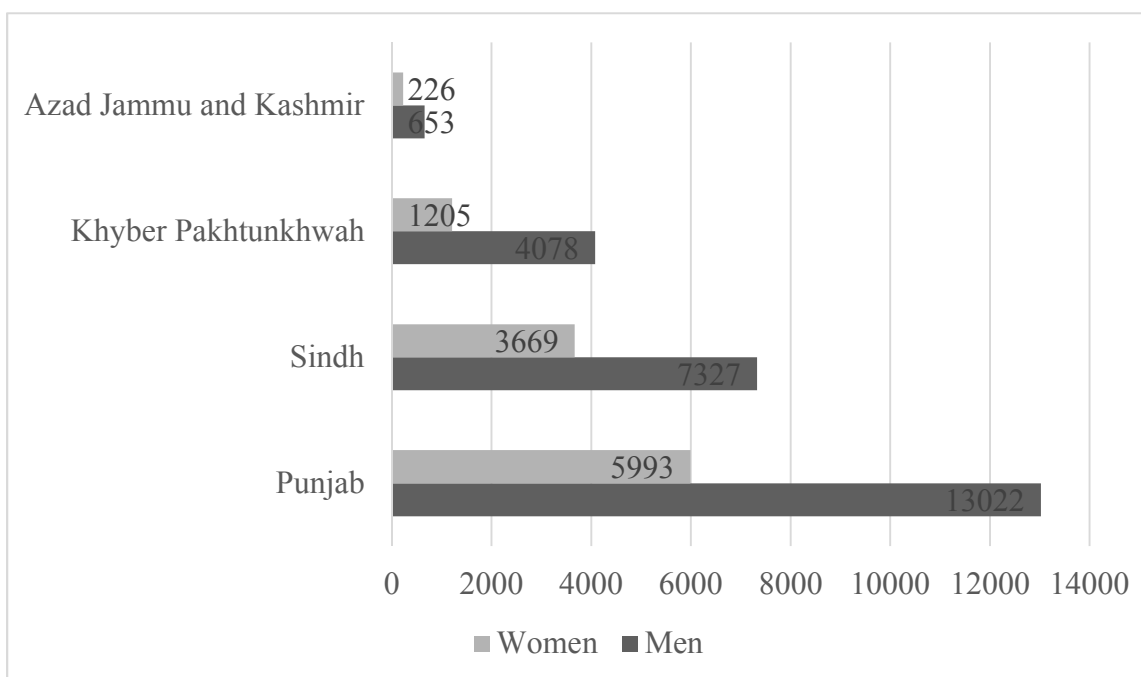


Figure 17. Gender-wise Distribution of Specialist Doctors in Provinces of Pakistan\*

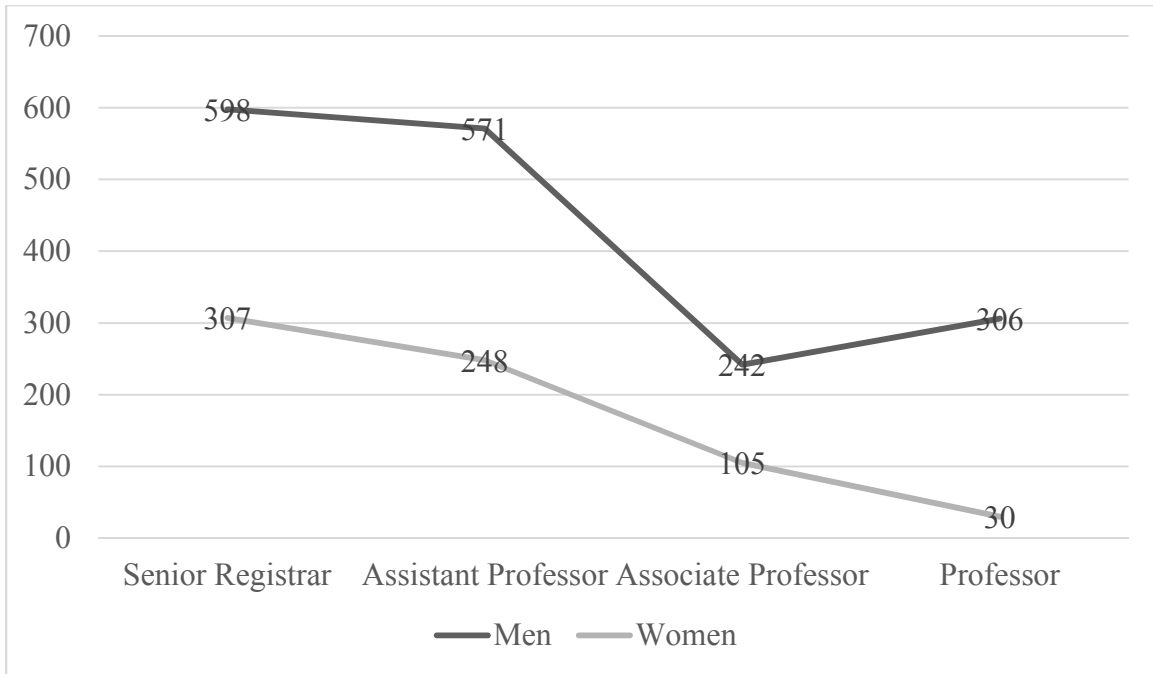


Figure 18. Gender-wise Distribution of Doctors through Various Ranks in Teaching Hospitals, Punjab, Pakistan\*\*

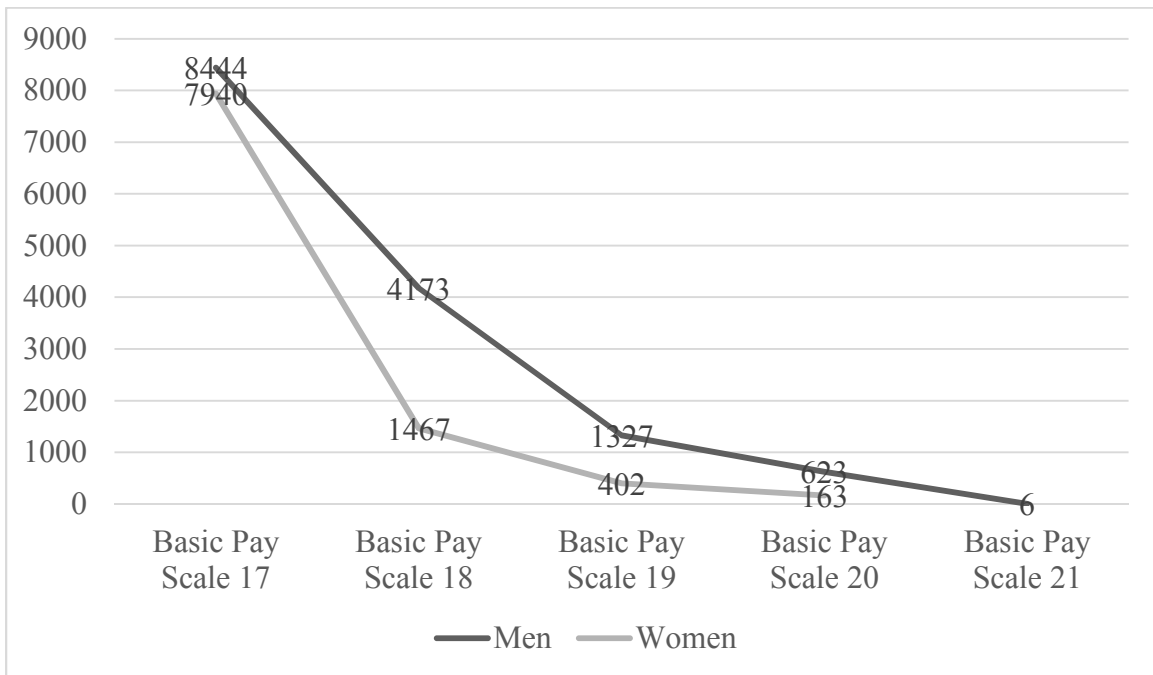


Figure 19. Gender wise Distribution of Doctors According to Pay Rank in Tertiary Care Hospitals, Punjab, Pakistan\*\*

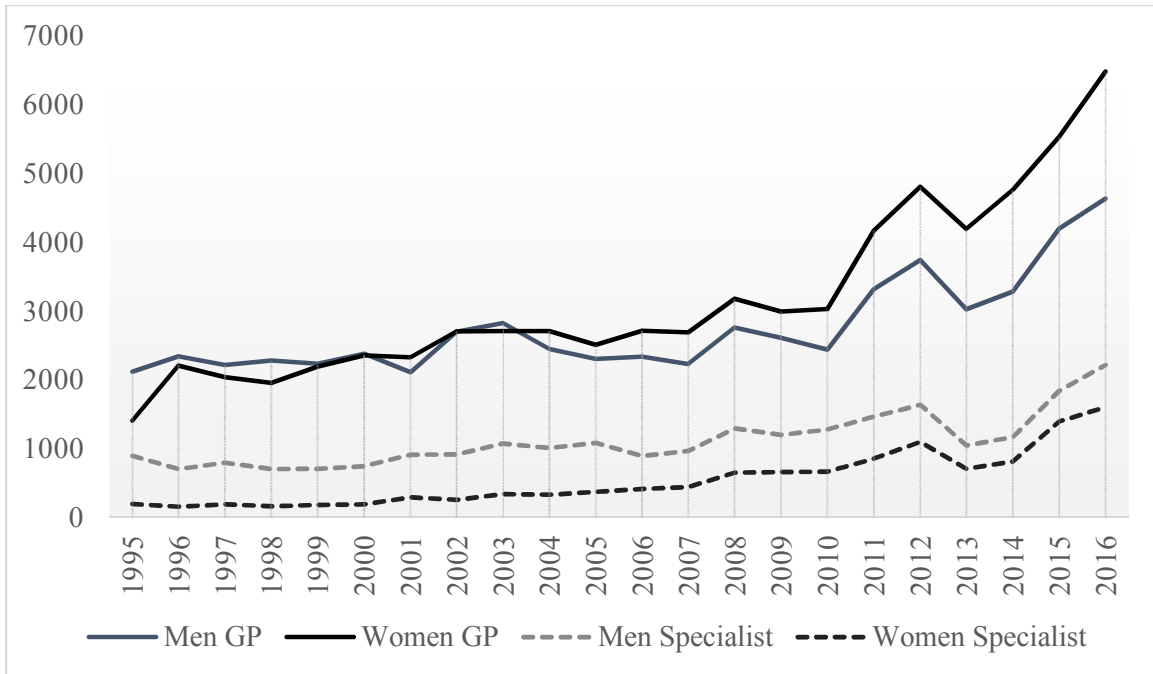


Figure 20. General Practitioners and Specialist Doctors Registering with Pakistan Medical and Dental Council since 1995 (Yearly, Gender-wise)\*

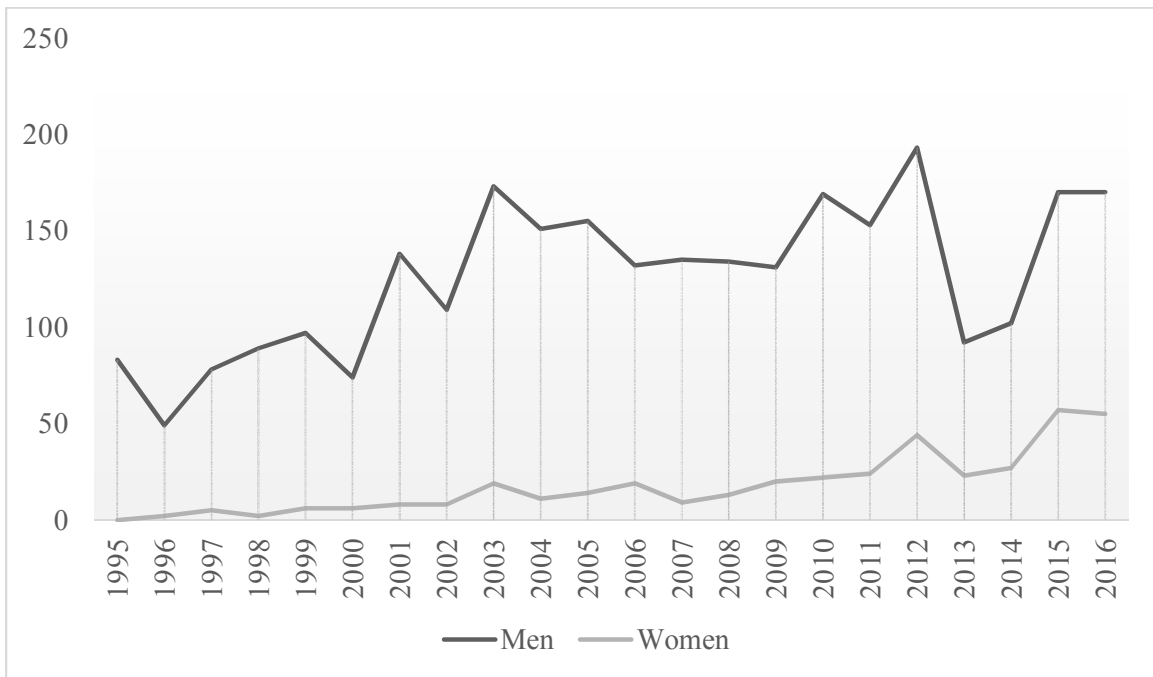


Figure 21. Doctors Specializing in Surgery in Pakistan since 1995 (Yearly, Gender-wise)\*

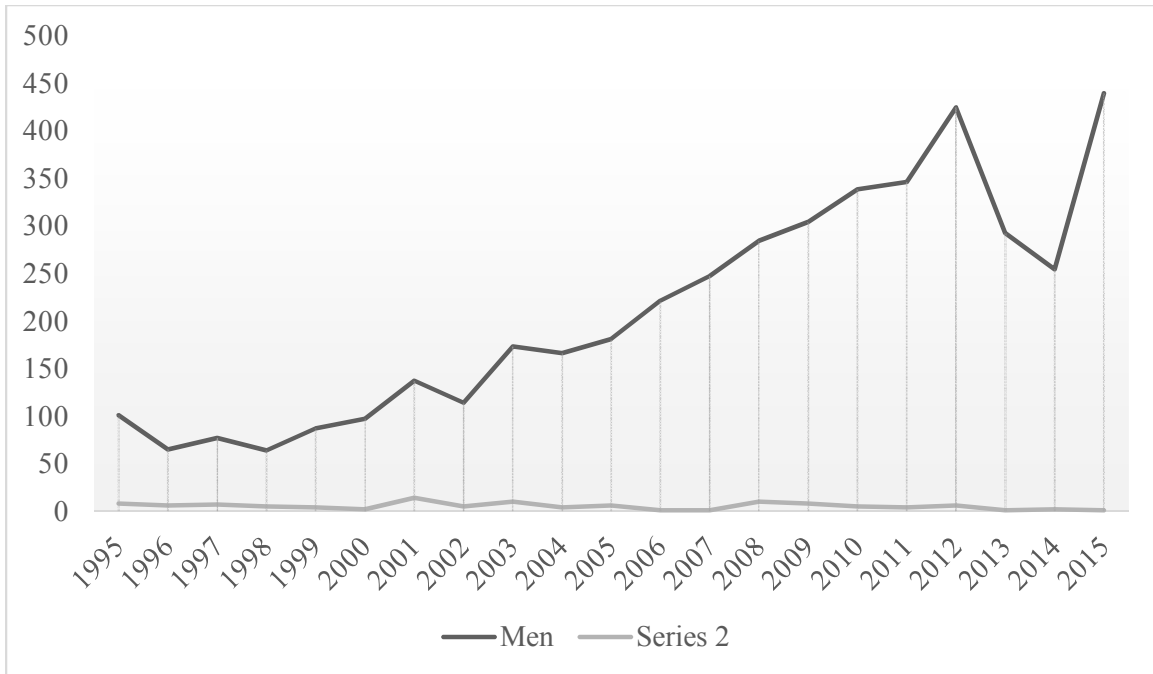


Figure 22. Doctors Specializing in Gynecology and Obstetrics in Pakistan since 1995 (Yearly, Gender-wise)\*

\*Data obtained from Pakistan Medical and Dental Council

\*\*Data obtained from Department of Specialized Health Care of Punjab, Pakistan

## APPENDIX B

### DEMOGRAPHIC DETAILS OF THE PARTICIPANTS

Demographic Profile	Number of women doctors
At least one child below 18 years	37
Age 25 years and below	4
Age between 25 to 35 years	27
Age between 35 to 45 years	15
Age 45 and above	10

Table 3. Demographic Profile of Participating Women Doctors

Employment Status	Number of women doctors
Unemployed as a doctor	15
Self employed	4
Formally employed	34
Formally employed and Private practice	3
Total	60

Table 4. Employment Status of Participating Women Doctors

Name of Institute	Number of women doctors
King Edward Medical University (Formerly College) KEMU	19
Allama Iqbal Medical College	7
Fatima Jinnah Medical College	8
Rawalpindi Medical College	5
Nishtar Medical College	6
Quaid-e-Azam Medical College	3

Lahore Medical and Dental Council	4
Punjab Medical College	2
Services Institute of Medical Sciences	1
Bolan Medical College	1
Liaquat Medical College	1
Total	60

Table 5. Medical Schools of Participating Women Doctors

Educational Attainment	Number of women doctors
Medical graduation (MBBS) only	22
Post-graduate trainee	11
Post graduate/specialist	27
Total	60

Table 6. Educational Attainment of Participating Women Doctors

Type of school	Number of women doctors
Gender segregated schooling only	35
Mixed (some schooling in girls-only schools and rest in co-educational)	15
Co-educational schooling only	10
Total	60

Table 7. Early Schooling Profile of Women Doctors

Medical Specialty	Number of women doctors
Gynecology	10
Pathology	8
Dermatology	2
Medicine	6
Surgery and Allied	5
Ophthalmology	1
Pediatric Medicine	4
Radiology	4
Basic Sciences (Anatomy, Physiology, Biochemistry)	3
Psychiatry	1
General Practitioner (no specialization)	16

Table 8. Medical Specialty in which Women Doctors Work or Have Post-Graduate Training

Official Rank	Number of employed participants
House officers	3
Medical officers	24
Assistant Professor	7
Associate Professor	5
Professor	2
Total	37

Table 9. Participant Women Doctors in Organizational Hierarchy



Marital Status	Number of women doctors
Married	49
Never married	9
Married, Divorced	2

Table 10. Marital Status of Participant Women Doctors

Demographic Profile	Number of participants
Average years of schooling (mother)	12
Average years of schooling (father)	16
Average years of schooling (husband)	18
Employment status of mother (unemployed)	49 (82%)
Employment status of mother-in-law (unemployed)	54 (90%)

Table 11. Demographic Profile of Family

## APPENDIX C

### POLICY STRUCTURE IN PAKISTAN FOR WOMEN IN WORKPLACE

## **Policies Based on Gender difference**

Policies based on the assumption that women deviate from the norm of “ideal worker” that is assumed to be masculine, and they can be accommodated as special needs within organization structure (Fox 1998).

1. The only protective policies and laws on basis of sex can be made for women and/or children. (Article 26, Constitution of Pakistan)
2. Women cannot work in the same industries as men (Factories Act, 1934)
3. Specified posts and services can be reserved for persons of a specific gender, if such services cannot be adequately performed by the other sex (Section 27, Constitution of Pakistan, 2010)
4. 10% quotas for women in public positions.
5. Maternity leave:
  - Paid maternity leave of 12 weeks (6 weeks before childbirth and 6 weeks afterwards) for women employed for at least 4 months. (The West Pakistan Maternity Benefit Ordinance, 1958; The Mines Maternity Benefits Act, 1981)
  - Paid maternity leave of 90 days for female civil servants, up to three times in whole career. (The Civil Servants Act, 1973; Revised Leave Rules, 1980)
  - Maximum of two maternity leaves allowed during training period, one paid, one unpaid. (Proposed Central Induction Policy)

- Maternity benefits contribution made through social security for secured provincial employees. (The Provincial Employees Social Security Ordinance 1965)

#### 6. Childcare:

- Provision of Childcare facilities (Labor Policy 2010).
- Childcare facility in every organization that employs more than 50 women for children less than 6 year of age (Factories Act 1934, Section 33 Q).
- Said facilities are reserved for children, their attendants and the mothers of the children. Establishment is also required to hire trained nurse and female servant for Childcare center (Punjab Factories Rules 1978).
- Detailed instructions on provision of facilities of childcare (Guidelines and Standards of Day Care Center, Women Development Department, Government of Punjab).
- Health institutions including medical colleges and teaching hospitals are required to provide daycare facilities for female employees (Criteria for evaluation of Medical institutions, Pakistan Medical and Dental Council).

#### 7. Breastfeeding provisions

- Childcare centers can be used by mothers to breastfeed in meal breaks (Factories rules, 93 Section 33-Q)
- Daily reduction in working hours or regular breaks for breast feeding, in addition to meal breaks (ILO Convention 183)

#### 8. Family Care

- Contribution towards family's medical care can be paid through social security. (The Provincial Employees Social Security Ordinance 1965)
  - No provision of leave for family care, though public servants can use leave periods stipulated in service codes for this purpose (The Civil Servants Act, 1973; Revised Leave Rules, 1980)
9. Mourning Leave: Special leave (paid) of 130 days for woman civil servants immediately after death of her husband (The Civil Servants Act, 1973; Revised Leave Rules, 1980)

### **Policies Based on Gender Equality**

Policies based on the assumption that there is no difference between men and women and if existing conditions are replicated for women, their career success can be ensured (Fox 1998).

1. No distinction can be made on the basis of sex alone (Article 25, Constitution of Pakistan).
2. No citizen qualified for a job can be discriminated against on the ground of race, sex, religion, caste, residence or place of birth, though no mention of being a parent; only for public sector jobs (Article 27).
3. Just and humane conditions of work for every worker (Article 37).
4. Full participation of women in every area of national life (Article 34).
5. State shall protect the marriage, the family, the mother and child (Article 35).
6. Equal remuneration for work of equal value, with no distinction between sexes (West Pakistan Minimum Wage Rule 1962).

7. Sexual harassment of any worker is punishable offense (Protection against Harassment of Women at Workplace Act 2010).

APPENDIX D

TIME USE BY MEN AND WOMEN IN PAKISTAN

Activity Categories		Total		Urban		Rural	
		Men	Women	Men	Women	Men	Women
SNA	Work in Establishment	119	10	77	6	187	18
	Primary Production	110	46	166	68	15	5
	Work in Non Establishment	93	22	80	24	114	19
Extend ed SNA	Household Maintenance	17	231	16	235	18	224
	Care of Persons	9	55	10	59	8	46
	Community Service	2	1	2	1	1	2
Non SNA	Social and Cultural Activities	193	142	199	144	183	138
	Mass Media Use	50	52	34	35	76	82
	Person Care	767	824	780	823	745	826

Table 12. Minutes Spent per day by Men and Women in Pakistan in Various Activities\*

\*Data obtained from Time Use Survey 2007, Pakistan Bureau of Statistics.