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South Asian Americans Involvement in Medicine

I was surprised to learn that Indian American physicians alone now account for nearly 8% of practicing doctors in the United States—a figure highlighted by the American Association of Physicians of Indian Origin (AAPI). This statistic shows something that isn't always obvious when we visit a hospital or clinic: the sheer extent to which immigration laws have shaped the medical professionals we rely on. While it's easy to assume those doctors simply arrived through their own ambition, the backstory is more nuanced, tied directly to policy reforms that opened—or sometimes nearly closed—the nation's doors.

For decades, America's immigration system was stacked against Asian immigrants. Quota laws going back to the 1920s set painfully low limits for entire continents, effectively shutting out South Asians (and most other Asians) from establishing any significant presence here. That meant if a talented surgeon in Mumbai or Lahore wanted to pursue opportunities in the U.S., they would run headlong into visa hurdles and harsh biases, often leading them to abandon the idea. A few made it on exchange programs or under highly specialized allowances, but it was more of a trickle than a steady flow.

Everything changed in 1965 when the Immigration and Nationality Act—commonly known as the Hart-Celler Act—officially dismantled the discriminatory quota system. For the first time in decades, American hospitals, particularly those struggling with physician shortages, looked abroad. As historian Erika Lee notes in *The Making of Asian America*, these policy shifts "remade the demographic landscape of Asian America, allowing an influx of highly educated and professionally trained newcomers" (Lee, Chapter 7). Suddenly, doctors from India, Pakistan, Bangladesh, Sri Lanka, and Nepal found themselves in demand, offered positions that could lead to permanent residency or citizenship.

Many of these newcomers were accustomed to different healthcare systems. In interviews, some recall wrestling with the U.S. board certification process, or contending with skeptical colleagues who dismissed them as "foreign doctors." Others mention that they were expected to work in underserved areas—often miles away from any existing South Asian community—just to secure their visa waivers. While these relocations could be isolating, they also helped a lot of struggling hospitals stay afloat, effectively bridging gaps in patient care that local physicians had not filled.

Over time, professional groups like AAPI became a support system, guiding newcomers through licensure questions, credentialing, and cultural adaptation. They also advocated for policy improvements, ensuring that skilled doctors weren't stymied by bureaucratic backlogs. As these physicians settled in, they often laid down roots, sponsoring spouses, parents, and even siblings under family reunification clauses—another element of the 1965 reforms. Consequently, many South Asian immigrant families started to cluster near hospitals and clinics, forming pockets of cultural connection in places that previously had few (if any) South Asian residents.

Without the removal of strict national origins quotas, many of the doctors we now rely on would never have arrived. Their story shows how immigration policies can influence who enters the country—and ultimately, the quality of care we all depend on.

Works Cited

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