Identity, Migration, Community Cohesion and Healthcare:

A Study of Overseas-trained South Asian Doctors in England and Wales

A thesis submitted to
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School of Social Sciences
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<td>British Medical Association</td>
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<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic Community</td>
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<tr>
<td>DCH</td>
<td>Diploma in Child Health</td>
</tr>
<tr>
<td>FRCP</td>
<td>Fellow of the Royal Colleges of Physicians</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HA</td>
<td>Health Authority</td>
</tr>
<tr>
<td>IMD</td>
<td>Indices of Multiple Deprivation</td>
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<tr>
<td>IMS</td>
<td>Indian Medical Services</td>
</tr>
<tr>
<td>MRCP</td>
<td>Member of the Royal Colleges of Physicians</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>OBE</td>
<td>Officer of the Most Excellent Order of the British Empire</td>
</tr>
<tr>
<td>PLAB</td>
<td>Professional and Linguistic Assessment Board</td>
</tr>
<tr>
<td>RCPE</td>
<td>The Royal College of Physicians of Edinburgh</td>
</tr>
<tr>
<td>TRAB</td>
<td>Temporary Registration Assessment Board</td>
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ABSTRACT

Community cohesion in Britain has been an issue of policy concern in recent years in which the role of migrants in the UK has been scrutinised in terms of their sense of belonging, integration and their economic and social contribution to society. However, much of the existing literature, in this area relates to the experiences of low/unskilled labour migrants. This thesis redresses this imbalance and examines the experiences of overseas-trained South Asian doctors. It provides unique insights into the debates about integration, cultural identity and community cohesion based on an empirical study of overseas-trained South Asian General Practitioners who are elite migrants.

A mixed method approach was employed that included secondary data analysis of the GP Workforce Statistics and in-depth interviews with 27 overseas-trained South Asian doctors in three different geographical locales in England with varying ethnic populations.

The quantitative analysis shows that a significant and increasing proportion of NHS doctors continue to be overseas-trained South Asian doctors. It also provides evidence of geographical clustering with South Asian doctors being over represented in deprived areas with high and low ethnic minority concentrations. The case studies and interviews with the GPs reveal a complex intertwining of macro-, micro- and meso-structures in the migratory process, related, in part, to the legacy of empire and also to the inner workings and opportunities provided by an organisation such as the NHS. In order to overcome blocked social mobility within the NHS hospital structure, entry into General Practice appears to be an entrepreneurial step for overseas-trained South Asian doctors, also facilitated by regional NHS institutional structures like Primary Care Trusts. Evidence shows that doctors have integrated their cultural/religious values creatively in their adaptation to Britain importing innovation into their everyday experiences.

The findings show that there are parallels to be drawn with the experiences of low/unskilled South Asians, in particular, in the area of structural integration. However, there is variation as to how these elite professionals approach issues related to socio-cultural integration thus adding a new dimension to our existing understanding of community cohesion in the UK.
DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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DEDICATION

In memory of my father, Nur Mohammad, a twice migrant (India-Pakistan-Britain) and a learned man who successfully passed on his thirst for knowledge to me,

Also dedicated to my mother Rehmat Bibi,

And

To my children, Faraz, Zara, Saba and Hina who have been a great source of inspiration throughout the period of this study.
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First and foremost, I would like to say how indebted I feel to Almighty God for His continuous guidance and goodness for allowing me to reach many milestones during the entire period of this research study. Undertaking this research study has been quite a journey in the last three years. It has led to so many interesting experiences and allowed me to meet a great number of people.

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And last but not least, I am truly and greatly indebted to my family who provided practical and emotional support throughout this study, in particular, to my daughter, Zara, for proofreading, commenting on my work and being an incredible teacher, and also to my brother, Nisar Ahmed for keeping me motivated. Many thanks must go to my daughter-in-law, Liza Molinari, who joined my family household during the course of this study and often provided me with lifts to and from the train station, and meals on late wintry evenings. She keenly read my chapters and was amazed to find that the migration trajectories of her own grandparents of Italian origin were, in many ways, not so dissimilar.

There was subtraction and addition in my family. Sadly, my father, who instilled in me the value of education passed away during my studies. On a happy note, I was blessed with my first grandson Amaan who joined our family this year.

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Chapter 1: Introduction

1.1 Introduction

In the last decade or so, community cohesion in Britain has been an issue of concern, in which the role of established migrant communities and new immigrants to the UK has been scrutinised in the context of how well migrants have integrated into British society. However, much of the existing literature in this area relates to the experiences of low or unskilled labour migrants.

This thesis aims to document the experiences of overseas-trained South Asian doctors, an elite group of migrants, who obtained their basic medical training in South Asian countries and subsequently migrated to the UK. Smith (1980) reports that in the late 1970s, 40% of hospital doctors and 20% of GPs in the UK were born overseas. They are the second single largest group of doctors working in the NHS after doctors qualified in the UK (Hann et al., 2008). Doyal et al., (1980, 1) comment on the invisibility of migrant workers in the NHS despite the fact that they make a significant contribution to the NHS:

...the extent and the details of their role in the NHS have gone almost entirely unrecorded.

Research studies in recent years have acknowledged the high level of workforce participation that is required by migrant workers in order to alleviate medical labour shortages in the NHS, but little is known about the impact of the migration of this elite migrant group, the nature of the social aspects of their lives and the roles that they play in their local communities. It is within this context that this study seeks to redress this imbalance, investigating the integration experiences of this distinct group.

This thesis shows that an understanding of the integration experiences of elite migrants such as overseas-trained South Asian doctors requires an appreciation of how we
comprehend the concepts of community cohesion. This will form the main focus in the following section that sets out the context of this research.

1.2 Research Context

Following the civil disturbances that occurred in several northern UK towns in 2001, ‘Community cohesion’ became widely regarded as the ‘new’ framework governing race relations policy (Worley, 2005). ‘Community cohesion’ became the subject of significant interest and a focus for major policy intervention by the last Labour government when it was defined, in its simplest form, as the extent to which people feel part of a community. The government definition, adopted in 2003 reads as follows:

A cohesive community is one where there is a common vision and a sense of belonging for all communities, the diversity of people’s different backgrounds and circumstances are appreciated and positively valued, those from different backgrounds have similar life opportunities, strong and positive relationships are being developed between people from different backgrounds in the workplace, in schools and within neighbourhoods (Home Home Office, 2003, 7).

Following the riots, the Cantle Report (2001) was the first published report to investigate their causes reporting that communities both white and Asian were polarised and segregated, and that people within these communities lived ‘parallel lives' with physical segregation of housing estates, educational arrangements, community and voluntary bodies, employment, places of worship, language, social and cultural networks, and therefore experienced a lack of meaningful interaction and community cohesion. Since then, the question of migrant identities has become more pertinent than ever because in the government’s community cohesion agenda identities are perceived to be necessary for community cohesion (Khan, 2007). It is argued that our identities are socially produced
and that they determine our relationships with the external world. Norton (1997, 410) describes identity as follows:

...
how people understand their relationship to the world, how that relationship is constructed across time and space, and how people understand their possibilities for the future.

Jenkins (1994) and Nagel (1994), argue that studying immigrant identities is central to our understanding of their integration into mainstream British society. Gilchrist et al. (2010) explain the significance of one’s identity in the community contending that it is important to recognise how people ‘define, resist or adapt’ their identities so as to enhance our own understanding of their engagement with their fellow citizens and with government. Welzel et al. (2005) contend that an individual’s level of involvement in the community is determined by his or her personal attributes as well as being conditioned by the level of opportunities to which they are exposed. This implies that contextual factors need to be considered alongside socio-economic background when analysing the differences between individuals and how well they integrate into the communities as migrants; those with different social statuses may have different identities and integration experiences in different contexts. It is vitally important to develop an understanding of the dynamics that impact cohesion in order to ensure effective policy interventions (Jayaweera and Choudhary, 2008).

This study aims to identify factors that play a key role in the integration process of elite migrants and endeavours to capture and reflect on the social interaction and place integration of overseas-trained South Asian doctors in Barnsley, Sheffield and Manchester, UK. It does this with the anticipation that localities of varying geographical scales are likely to have an impact on individuals’ identity and community cohesion experiences (Holy and Stuchlik, 1981; Commission on Integration and Cohesion, 2007).

1.3 Why Study the Experiences of Overseas-trained South Asian Doctors?
Overseas-trained South Asian doctors constitute a large proportion of highly-skilled migrants to the UK, yet they remain an under-researched group. Highly-skilled migrants are defined as individuals with university degrees or those having extensive or equivalent experience in a given area (Iredale, 2001). Several categories have been used to describe migrants who are at the higher-end of the skill, such as professional, highly-skilled, international migration, highly-educated and elites (Favell et al., 2007). In this thesis, I will use the term elite to refer to the highly-skilled professional migrants such as the overseas-trained South Asian doctors.

The growing body of community cohesion literature lacks specific empirical data regarding what accounts for the particularities of elite migrants such as this group in the UK, and how they settle in their respective communities, post-migration. The elite status of overseas-trained South Asian doctors makes them an interesting group to study for underexplored perspective on whether and how patterns of inequality that are generally experienced by minority ethnic groups also affect this elite group of migrants. There is also a general lack of an appropriate methodological framework in this area of research (Iredale, 2001).

This study focuses on the integration experiences of doctors who are overseas-trained South Asian doctors who practice as General Practitioners (GPs). The term ‘South Asian’ is a descriptive category that applies to a geopolitical region that including the countries of the Indian subcontinent, namely, India, Pakistan, Sri Lanka and Bangladesh (Sahoo and Maharaj, 2007, 13). The study excludes those South Asian doctors who were trained in the UK for its recognition of the distinct nature of the experiences of being migrants. The term overseas-trained South Asian doctors will be employed throughout this thesis in order to gain collective insights into their personal journeys from migration to settlement, however, where material specifically relates to the experiences of General Practitioners within this group, distinctions will be made accordingly.
McNair (2009) refers to migration as taking various forms whereby people migrate with different hopes and aspirations, have different needs and the kind of reception they encounter also differs from one another. Migration brings challenges and opportunities for the countries involved. An official report *Community Cohesion and Migration* (2008, 3) refers to public service pressures and tensions between migrant and settled communities, although also acknowledges that a significant contribution is made by many migrants to local communities and public services, in particular the NHS. While there are ongoing debates about issues arising from the community cohesion agenda such as migrants’ identity, sense of belonging, common values, notion of community, with a substantial body of research now existing that relates to the experiences of migrants, generally, empirical evidence is lacking as to how the overseas-trained South Asian doctors work through such issues, even though they have a disproportionately higher representation in the NHS workforce.

This study aims to contribute to the public debates on ‘community cohesion’ by providing findings on the social aspects of these migrant doctors’ experiences. It recognises that the kind of reception encountered by these elite migrants who are able to speak English and belong to a higher social class as a result of their professions, may be different as public concerns generally relate to debates about new migrants taking existing residents’ jobs and overloading welfare services (McNair, 2009). The time period considered is the 1960s onwards, as this time frame encapsulates the era of their significant migration into the UK (World Bank, 1993).

GPs in the UK are based in primary care settings and treat acute and chronic illnesses as well as provide preventive care. They are the first point of contact for most patients.¹ As health care professionals, the doctors have a wide remit for the provision of health and

---

¹ Royal College of General Practitioners
social care to their patients and they are, due to their unique position, often at the ‘heart of networks within and between communities’ (Farmer et al., 2003, 673). An understanding of their experiences can shed light on many of the above mentioned hotly debated topics related to community cohesion. GPs, in particular, often have intimate relationship with local communities and this makes them an interesting group to study as they are likely to have a unique insight into the lives of their patients (Wise, 2010). Anecdotal evidence suggests that overseas-trained South Asian doctors are more than healers and as social actors they play a vital role in wider community engagement which is an important element of community cohesion agenda (Sayeed, 2006).

Research to date clearly shows that the persistent nature of racism is seen as a general part of everyday life for minority ethnic communities in Britain (Chahal and Julienne, 1999). Research studies have also highlighted that the NHS is no less affected by racism than any other parts of UK society. Unwin (2001) contends that overseas-trained doctors face discrimination throughout their working lives and are often forced into career paths that deny them equality of opportunity. The study of Esmail and Robert (2013) is the most recent study that reported nearly 65% of overseas-trained doctors and 17% of ethnic minority graduates trained in the UK fail clinical skills assessment examination required to become an accredited General Practitioner at the first attempt when this figure was only 4% for white UK-trained doctors. The authors add that subjective bias in the nature of such assessment due to racial discrimination may be a cause of such large discrepancy. Anecdotal evidence also points to the widespread existence of the racial harassment experiences of black and minority ethnic (BME) staff in the NHS (Collins, 2001). However, there is little empirical evidence available in relation to how racism is experienced by overseas-trained South Asian doctors and what coping strategies are employed by them to overcome such barriers to integration.
1.4 Research Objectives and Key Questions

The aim of this research is to investigate the integration experiences and perspectives of overseas-trained South Asian doctors in the UK. Erdal and Oeppen (2013) deconstruct integration into two separate dimensions, *structural* and *socio-cultural*. The former refers to the more ‘functional’ and easily measureable aspects of integration, for example, how migrants are incorporated into societal structures such as the labour market or education, whereas the latter encompasses the more complex aspects of integration, such as the social networks that connect migrants and majority populations, as well as the emotions of belonging or being at home which are more difficult aspects to measure (Snel et al., 2006).

The structural element in this study includes determining the scale and trends of migration for overseas-trained South Asian doctors to the UK and the characteristics of the localities. Socio-cultural integration is explored by way of qualitative research that examines multiple processes from migration to integration, particularly considering access to social networks, and the types of social capital that enhance integration. In addition, the study aims to evaluate the relative impacts of different environmental factors on individuals’ identities.

The thesis also aims to examine how the integration experiences of elite migrants such as overseas-trained South Asian doctors relate to the existing theories of migration, social capital, entrepreneurship and transnationalism. The main research question of this study is:

What insights do the ‘lived experiences’ of highly-skilled elite labour migrants such as overseas-trained South Asian doctors add to our understanding of community cohesion?

Table 1.1 below outlines how the above aims and objectives were translated into sub-questions.
Table 1.1 Key Research Questions

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<td>1a) What were the proportions of overseas-trained South Asian doctors in the total UK GP workforce over the period 1992-2009?</td>
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<td>1b) What were their demographics, key locations of employment and how did this pattern change over the period 1992-2009?</td>
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<td>2) What perceptions do overseas-trained South Asian doctors have of their mobility in the NHS in terms of working conditions and career development and of their contributions?</td>
<td>Chapter 5-6</td>
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<td>3) How have different contextual factors impacted on the overseas-trained South Asian doctors’ identities and their perception of the communities around them?</td>
<td>Chapter 7</td>
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<td>4) What insights do the ‘lived experiences’ of these highly-skilled elite labour migrants add to our understanding of community cohesion and how do their experiences relate to existing theories of migration, social capital, entrepreneurship and transnationalism?</td>
<td>Chapter 5-7</td>
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1.5 Methodology

I employed a mixed method and a case study approach that included a descriptive analysis and in-depth interviews with 27 overseas-trained South Asian doctors which were conducted between 2011-2012 in Manchester, Sheffield and Barnsley. A secondary data analysis of the GP workforce over the period 1992-2009, examined the structural integration and the qualitative research was used to answer questions related to socio-cultural integration.

A sequential approach was used in which quantitative data analysis served as a basis for the next data collection and analysis stage. The rationale for mixing quantitative and qualitative data was to develop to a more comprehensive and complete understanding of the research questions. The broad research question was about investigating what insights the ‘lived experiences’ of highly-skilled elite labour migrants such as overseas-trained South Asian doctors add to our understanding of community cohesion. This required
deconstruction of the concept of integration that required investigation at two levels, structural integration and socio-cultural integration where the former could be measured quantitatively and the latter by qualitative research for its subjective nature.

The quantitative data analysis in this study provided an insight into the context of the research questions which were explored in more detail in the qualitative data. The quantitative data enabled an analysis of key issues related to the thesis such as the scale of the migration over the years, the characteristics of the doctors such as their country of qualification, age, gender and the geographical areas these overseas-trained South Asian doctors were located. The results helped determine the validity of case study areas. The choice of Barnsley, Sheffield and Manchester was motivated by the similarities and the differences in their locations. The descriptive analysis showed that these three areas have a high density of overseas-trained South Asian doctors. Census data was used to determine ethnic density of these areas which needed to be contrasting.

Though the workforce data is only available for the period 1992-2009 and provides statistical analysis for that period, an analysis of the demographic characteristics of the doctors in the qualitative study showed that their migration pre-dated 1992 and all the doctors came to the UK prior to 1992 (Figure 5.1 (p-131) provides more detailed information regarding year of arrival for Indian and Pakistani origin doctors in the UK). This meant that the doctors were able to articulate their experiences retrospectively. The quantitative analysis helped identify questions that were later explored in the qualitative data. For example, the doctors were asked of their perceptions relating to a number of findings that related to discrepancies in age, sex and patterns of their geographical distribution in General Practice in comparison with the UK-trained doctors.

In other words, the quantitative exploratory analysis provided important context for the more in-depth qualitative analysis. It was anticipated right from the outset that neither
quantitative nor qualitative methods were likely to be sufficient in themselves in capturing the issues and answer the research questions. A detailed discussion of the methodology can be found in Chapter 3.

1.6 Structure of Thesis

The thesis is organised into eight chapters. Chapter 2 provides the theoretical foundations of this study together with discussions of the main concepts to be explored such as migration, experiences of racism, social capital, community cohesion, place attachments, sense of belonging and transnationalism. Chapter 3 describes the methodological considerations which guided this study. It outlines the methodological framework providing information on the data sources, a detailed discussion of the adoption of a research design that employs a mixed-methods strategy and a case study approach. The discussion includes separate detailed descriptions of each method together with justification for its use as well as a discussion of its limitations, the data collection methods and analytical procedures used, any ethical issues arising in the research, with reference to the relevant literature, and my own contribution in the research process as a researcher. The description of case study areas is provided together with the rationale for their selection. The first part of the data analysis discusses the descriptive statistical analysis while the second part covers the qualitative data analysis that goes beyond raw numbers to examine the migrants’ experiences and their own reflections.

The next four chapters (4-7) present the results. Chapter 4 outlines the results obtained by the use of quantitative analysis. Chapter 5 discusses, in depth, the results obtained by the qualitative analysis and provides detailed descriptive accounts of the interviewees’ journeys from pre- and post-migration which sum up the economic, social, political and cultural practices involved in the overseas-trained South Asian doctors’ migration process. The data is organised thematically. Chapter 5 also looks at how macro-, micro- and meso-
structures interact, and can explain the nature of the overseas-trained South Asian doctors’ migration.

Chapter 6 explores doctors’ experiences from migration to settlement, illustrating how they negotiated their entry into the General Practice utilising an entrepreneurial process and then considers the factors leading to the downside of such a process.

Chapter 7 provides a description of the case study areas and examines the push/pull factors involved in the choice of geographical localities, the doctors’ experiences of social interaction, and how they were able to fit into their respective communities. It explores how identities are experienced in each of the case study areas and how the local environment impacts on their feeling of belonging to Britain.

The final Chapter 8 examines how the study has answered the research questions that it set out to investigate. It presents the overall findings of the study, draws the areas of discussion together and proposes policy recommendations. It concludes with a discussion of the potential for further research into community cohesion policy.
Chapter 2: Developing a Conceptual Framework and Review of the Literature

2.1 Introduction

This thesis aims to investigate the integration experiences of overseas-trained South Asian doctors and examine whether the privileged position of elite migrants such as this group makes their experiences distinctive from the experiences of their low/semi-skilled counterparts. In this chapter, I will discuss the theoretical concepts that influenced the direction of this study and explain what relations are to be further analysed.

This study is concerned with structural and socio-cultural integration and will also explore, through case studies of Barnsley, Sheffield and Manchester, both aspects of integration and how the experiences of overseas-trained South Asian doctors are influenced by local factors. This broad objective has helped delineate some preliminary key themes and areas for the literature search were: community cohesion, and migratory and settlement experiences of overseas-trained South Asian doctors. Under the umbrella term of ‘community cohesion’, further areas were identified to include the development of the concept and debates surrounding community cohesion, migration theory concerning overseas-trained South Asian doctors, employment patterns in the UK, racism in the NHS, social entrepreneurship, identity and diversity. Each of the above themes will be discussed under sub-headings.

2.2 Developments in the Community Cohesion Debate

According to the Institute of Community Cohesion, the term ‘community cohesion’ is not new in the writing of political theorists’, and can be broadly applied to ‘describe a state of harmony or tolerance between people from different backgrounds living within a
However, the concept of community cohesion has evolved over the last few years.

Following the urban disorder that occurred in Bradford, Oldham and Burnley in 2001, much of which was attributed to racial tension, several government reports were published investigating the status of community relations in the cities that experienced the disturbances (Clarke, 2001; Ouseley, 2001; Ritchie, 2001; Denham, 2001). All these reports identified the ‘segregation’ of different racial groups as a significant contributory factor towards the disturbances. The concept of community cohesion re-emerged when the government reports concluded that a lack of community cohesion was a fundamental cause in these riots (Jayaweera and Choudhary, 2008). This absolute separateness, based on religion, education, housing and employment, and leading to a lack of contact and knowledge about each other’s group was envisaged to have contributed to the growth of fear and conflict (Cantle, 2001). The diversity issues that had previously been promoted under the remit of multicultural policy were now considered in a negative way. Following such an analysis, community cohesion became an important goal of British public policy. Initiatives aimed at promoting community cohesion required a built-in process for ensuring that their impact could be measured (Jayaweera and Choudhary, 2008). The Home Office biennial Citizenship Survey of England and Wales was an example of such measure. Here, the emphasis was placed on acquiring a national identity, this was perceived as ‘potential super glue’ for those communities considered to be too diverse and divided (Wetherell et al., 2007).

The Commission on Integration and Cohesion (CIC) undertook development work that involved adopting a clear definition of community cohesion before it could be incorporated into the policy framework. Various national indicators were initially used against which

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2 The Institute of Community Cohesion was established in 2006 to provide a new approach to race, diversity and multiculturalism following the urban riots in Lancashire. http://www.cohesioninstitute.org.uk/Resources/Toolkits/Health/TheNatureOfCommunityCohesion
each area was measured for its cohesiveness. In 2008, the commission provided following
definition of community cohesion and integration:

*Community Cohesion is what must happen in all communities to enable
different groups of people to get on well together. A key contributor to
cohesion is integration which is what must happen to enable new and existing
residents to adjust to one another* (DCLG, 2008a, 10).

In order to tackle the problem of perceived ‘parallel lives’ as identified in the analysis of
the 2001 disturbances, the community cohesion policies introduced were of a multifaceted
nature drawing upon a diverse range of implicit rather than explicit ideas (Lowndes, &
Thorp, 2011). For example, the Community Cohesion Pathfinder Programme, a key
element of the government’s initiative on community cohesion, focused on the social
capital approach and increasing the level of intercultural communication. It was anticipated
that such an action brings would bring about increased cohesion (Ratcliffe, 2011).
Numerous toolkits and ‘best practice’ material were also developed by the Institute of
Community Cohesion and adopted by several local authorities. For example, the
‘Swapping Cultures’ project (DCLG, 2007) was adopted by 14 local authorities with a
view to increase understanding between young people from diverse ethnic, cultural and
faith backgrounds (Ratcliffe, 2011).

The social capital framework used to explain community cohesion policy goals, is
‘bonding’ and ‘bridging’ social capital’, which distinguishes between the various forms of
community interaction (Khan, 2007). Bonding social capital refers to social ties within
various community groups, whereas bridging refers to social ties across social groups, they
have also been referred to as inclusive and exclusive respectively. Importance has been
accorded to bridging social capital that connects across groups rather than bonding social
capital that strengthens ties within groups. The above premise is based on a broad body of
social psychological work on the nature of prejudice and discrimination by the influential
contribution of Allport (1979) occurring within the American context, it set the agenda for
subsequent work for what is now known as ‘contact theory’. This theory was subsequently brought to prominence in the UK by Hewstone et al. (2007).

The policy focus of the Community Cohesion Framework has also been shaped around ideas of common vision and sense of belonging in order to move towards the integration and cohesion of ‘different’ communities into a (British) whole (Worley, 2005). However, despite the growing interest in the value of cross-cultural interactions and in the ethos of Community Cohesion Framework literature, there appears to be a gap in the knowledge as to how elite migrants manage such processes and their own identity.

The discussion so far has outlined the developments leading to the adaptation of community cohesion policy and its implementation by means of various initiatives. The following section discusses the criticism related to the theoretical and policy framework in this area.

2.3 Critiques of Community Cohesion Discourse

Whilst the new Community Cohesion Policy acknowledges and respects the need for multiculturalism it places much greater emphasis on integration and cooperation between diverse cultures based on shared values, civic culture, social solidarity, social networks, social capital and mutual intercultural dialogue (Cantle, 2001). The critics of community cohesion have challenged this emphasis, arguing that multiculturalism still remains a valid and legitimate framework for reducing racial tension. Others argue that the new policy formulation seems a knee jerk reaction to the incidents that occurred in Lancashire’s cities and that it bears little reality to the experiences of a wider range of communities that do not have the issues that attracted such disturbances in the first place (Lowndes and Thorp, 2011).

Ratcliffe et al. (2008, 58) question the validity of ‘snapshot’ cross-sectional surveys to assess community cohesion with a tick box fixed-choice questionnaire approach, and argue
that the terminology used in indicators that measure the performance of community cohesion such as ‘community’, and ‘background and belonging’ are vague and ‘so broad as to permit person- and community-centered meaning of these indicators’. In other words, the above approach does not fully incorporate the elements related to ‘difference and local complexity’ and the simple descriptors applied subsume significant issues such as faith, gender, age and one’s economic class to such an extent that they affect the ability of the contextual data to help when it comes to the analysis of ‘causal processes’. According to the authors, there is a lack of sensitivity displayed in those indicators used to describe the types of social networks that the government itself identifies as characteristic of cohesive communities such as robust bridging (inclusive) and bonding (exclusive), social capital, and those issues have to be sensitive to ‘place’. Ratcliffe et al. (2008, 4) state:

This is critical to understanding the nature of community cohesion or disharmony, since it is a site where citizens experience everyday lived experience through a multitude of networks.

The authors emphasise the need for a collection of indicators to provide not only ‘contextual reading’ when measuring community cohesion, but also the types of indicators that ‘go beyond simple descriptors’ such as ‘background’ and ‘belonging’, as well as the necessity of defining ‘place’ since this is likely to vary between citizens and organisations (Ratcliffe et al., 2008, 58). Furthermore, quantitative methods cannot capture an individual’s subjective experiences in a survey.

Apart from the methodological flaws, there are a number of other areas which have attracted criticism. However, I will only discuss specific areas that directly relate to this study, this is because a detailed overview or critique of community cohesion policy in the UK is beyond the scope of this thesis. My focus is on two central themes that have attracted a lot of academic scholarship in relation to the Community Cohesion Framework. One relates to the fact that there is a lack of emphasis on the impact of racism within the policy framework that prevents structural integration of migrants whereas the other theme
relates to socio-cultural integration and what Parekh (2007) refers to as ‘exhorting people to become or feel British’. I will now discuss each of these themes in depth.

2.3.1 Racism and the Community Cohesion Framework

Intercultural Communication initiatives aimed at increasing the knowledge of ‘the other’ have been criticised for their failure to acknowledge the role of racism in achieving community cohesion. Ratcliffe (2011) points out that while the suitability of such initiatives is not disputed, it is the ideology implied in such approaches that has been the subject of much of the academic debate. Since cohesion policies are targeted mainly at the local level, problems are therefore perceived to be stemming from ethnic, cultural and religious difference rather than material and power-based inequality (Ratcliffe, 2011). The author adds that such an approach assumes that historically entrenched/endemic racism, and prejudice, can be educated away by simply employing cross-cultural interaction in the same way that multiculturalism posited that such differences could be ‘negotiated’.

In an article ‘It’s not about race. It’s about the community’: New Labour and ‘community cohesion’ Worley (2005), sums up the criticism relating to the community cohesion policy framework and pointing out that the concept of ‘community’ which is central to the community cohesion agenda has implications for processes in relation to lived experiences of race and gender and that such usage allows for language to be become de-racialised. The author also adds that the new framework also draws on earlier discourses of assimilation through notions of ‘integration’. Drawing on their own research, Yuval-Davis et al. (1989) additionally contend that the survival of ‘communities’ owes much to both gendered and racialised processes.

The social capital approach has been further criticised for the emphasis it places on bridging social capital following on from the criticism of the old multicultural policy which, it has been argued was pre-occupied with bonding social capital (Khan, 2007, 47).
Khan argues that the formation of bonding social capital can be an important way of providing disadvantaged communities with the necessary resources that eventually enables them to participate in the wider society with more confidence. There are also drawbacks associated with each of these networks. For instance, bonding social capital can serve to promote exclusionary practices. Khan (2007, 47) states:

...bonding social capital can work to exclude people; even those who draw strength and support from their existing social networks recognise the potential problems for such networks where they place constraints on group members.

Central to the above criticism is the argument that racial prejudice continues to play a significant role in ethnic inequalities. A key research question in this thesis is concerned with the nature of the structural and socio-cultural integration experiences of overseas-trained South Asian doctors who are an elite group of migrants as well as members of disadvantaged communities. This thesis can contribute to what type of social capital the elites in this study utilise and what strategies they employ to combat racial prejudice which has been historically described as ‘entrenched and endemic’ racism. Through their work, the doctors are likely to engage in cross-cultural interactions, and their experiences can shed light on whether or not prejudice can be educated away and, if the difference can be ‘negotiated’ as implied in the Community Cohesion Framework. In the following section, I will discuss the criticism that relates to identity debates.

2.3.2 Criticism Related to Identity Debates

In relation to identity debates, the pre-occupation of the community cohesion agenda with unitary national identity has been heavily criticised in the academic literature. Brah (1985, 9) draws on the earlier influential work of Berger and Luckmann (1971) who argued that identity is formed by social processes which are involved not only in the formation but also in the maintenance of identities, and that identities are produced in a dialectal relationship with society. They argue that identities are produced by an interplay between an individual
and their consciousness and social structures that react upon a given social structure, thus preserving, adapting or even reshaping them.

Ethnicity is socially constructed with an ethnic group referring to communities who feel a common sense of identity, often based on shared language, religion and cultural traditions (Coker, 2001). Brah (1985) argues that ethnic identity is a specific facet of an individual’s or a group’s global identity, and that it becomes meaningful to refer to ethnic identity only when two or more ethnic groups are brought into contact within a common social context with other ethnic groups. However, it is the social structure of society that determines the social context. To elaborate upon this further, Brah (1985, 9) also reminds us of colonial history and its impact on individuals:

_Thus discussions of ‘ethnic’ and cultural’ identity in contemporary Britain must be grounded in an analysis of the complex social and historical processes which account for the subordination of black groups in British society. It needs to be borne in mind that the social relations between white and black groups are predicated against a backdrop of colonialism and imperialism._

The above highlights two important points which are interlinked, one refers to the historical subordination of black groups in British society, and the other relates to the impact of imperialism on individuals’ identities. The legacies of colonialism and imperialism are of particular relevance in this study of elite migrants for reasons discussed in section 2.6, which discuss the role of overseas-trained South Asian Doctors, the surrounding controversies and contribution, together with the context of their migration. In a review of the contribution of South Asian doctors to the development of the NHS, Esmail (2007) reflects on the relationship between the NHS and Britain’s colonial past, suggesting that the role of Asian doctors in the NHS is a form of ‘indentured labour’. The author also draws attention to the perceived social images of British superiority that continue to play a role in the migration of overseas-trained South Asian doctors to the UK.
Worley (2005) is critical of the fact that the government reports refer to dichotomous constructions of identity rather than seeing identities as manifold, and valuing them as such. The author refers to paragraph 14 of the Home Office report:

*For those settling in Britain, the Government has a clear expectation that they will integrate into our society and economy because all the evidence indicates that this benefits them and the country as a whole . . . we consider that it is important for all citizens to have a sense of inclusive British identity. This does not mean that people need to choose between Britishness and other cultural identities, nor should they sacrifice their particular lifestyles, customs and beliefs. They should be proud of both.* (Home Office, 2005:45).

Worley (2005) argues that the above assertion ignores the fact that identities can also be and are transnational. Furthermore, there are other aspects across and through which identities are forged such as gender or religion. The above reinforces what Amin (2002) refers to as a place-bound notion of belonging which was identified by Cantle (2001) as one of the domains of community cohesion, that is, place attachment and an inter-twining of personal and place identity. Neighbourhood connections, helping one another and reciprocity are all can be seen to be significant from a local standpoint, with Putnam (2000) referring to them as aspects of local social capital whereas Faist (2000) argues that non-local social capital and connections are just as important for migrants.

In addition to the impact of community experiences, Pietka (2009) draws attention to the heterogeneity of ethnic communities such as the ‘hybrid ethno-national, ethno-local and ethno-transnational boundaries of social identity’ that are formulated and shaped by one’s social identity such as age, gender and social class position (Hesse, 2000). Snape (2005) argues that statistics used to describe participation in the context of ‘blanket term’ such as black minority ethnic groups mask significant discrepancies within groups with different racial and cultural backgrounds. Katbamna et al. (1998) also refer to the diversity of the South Asian community which has arisen as a result of their migration history, settlement
patterns, different languages spoken, as well as different religions observed, cultures practiced and their various socio-economic circumstances and social support networks.

Modood (1997, 291) points out that individuals from minority ethnic communities also have many ‘non-ethnic identities’ that are based on ‘occupation, neighbourhood, consumption, leisure and so on....’. In other words individuals are likely to experience the intertwining of personal, professional and place identities.

Parekh (2007, 133) also refers to the religious identity that constitutes the axis for individuals’ lives and provides them an overarching framework within which they define and relate their other identities, for instance, the author adds that many people of professional background from Christian, Muslim and Jewish faiths feel anxious as to how they can be good doctors, teachers, husbands and neighbours, and ask themselves what their religious values require them to do in these areas.

Experience of marginalisation and exclusion within the structures of white or Western hegemony leads minority ethnic groups to form diasporic transnational links. (Sahoo and Maharaj, 2007 Vol 2, foreword note). The authors contend that diasporas’ identity is based on a common ancestral homeland, however, one dispersed with a sense of marginality in the country of residence. A powerful strategy that has been employed by minority groups is that of claiming their differences and turning them into symbolic capital. In contemporary cultural studies, the ‘diaspora’ has increasingly become a popular term for that symbolic capital. Diasporas are described as key socio-cultural formations implicitly designated to overcome the constraints of national boundaries as well as the means through which people can imagine and align themselves beyond the nation Ang (2003) . Ang (2003, 143) states that:
Simply put, the nation-state is cast as the limiting, homogenising, assimilating power structure, which is now, finally, being deconstructed from within by those groups who used to be marginalised within its borders but are now bursting out of them through their diasporic transnational connections.

Ang refers to the ‘Chinese diaspora’ and how the desire among ethnic Chinese is not just about belonging, but about belonging to a respectable imagined community, one that infuses pride and identity. The view that shared experiences of being an immigrant enables diasporas to develop a sense of belonging to each other that they may never have otherwise developed is also supported by a study of South Asian engineers in Silicon Valley. Saxenian (2001) argues that historically, Indian society has many layers that divide its communities such as religion, region, and language; however, an overriding Indian identity proved to be more powerful for the immigrant South Asian engineers in Silicon Valley than any other distinction. Allen (1971, 168) states that this type of common identity among immigrants has developed as a result of their experiences of marginalisation in Britain as well as an ideology of past shared experiences of exploitation, namely colonialism. In their research study with immigrant physicians residing in Canada, Neiterman and Bourgeault (2012) found that the physicians integrated into the medical world, as a ‘professional diaspora’. The authors contend that the creation of a collective identity for these physicians owed its existence not to the traditional ethnicity denominator considered imperative for the creation of diasporic communities, but rather from other forms of shared values and meanings, that is, from a shared professional identity.

It is often assumed that the relationship of post-colonial people to Britain commenced only at the point when they or their ancestors embarked on their journey to Britain but this fails to take into account their exposure and conditioning under colonial rule (Sayyid, 2004). Studying the identities of these elite medical migrants is particularly interesting for reasons I shall discuss next.
There has been a long tradition of Indian students of law and medicine coming to Britain with a view to seek improved social status through acquiring western education which is rooted in the historical context of Indian history in which colonisation has played a significant part. Esmail (2007, 827) draws attention to the significance of this historical context stating that:

*Understanding how and why so many doctors from the Indian subcontinent work in the NHS cannot be separated from the relationship that Britain had with India.*

The author draws attention to the development of the medical profession in India and the Indian Medical Services (IMS) which demanding the adoption of modern scientific therapies, namely western medicine, in many of its urban areas, in preference to the long practiced system of traditional Indian medicine. It was not until 1855 that any non-European was allowed to enter the IMS. The Indian medical colleges only operated as licentiates on behalf of the IMS. Following the departure of the British in India, in and considering the future practice of medicine, the Indian government adopted the western model, whereby the new medical colleges inherited both western educational styles and IMS teaching staff. The new regulators of the medical profession were the Indian doctors who had previously collaborated with colonial rule (Esmail, 2007). Others also refer to the reforms which took shape when imposing the British medical system model on India and which replaced the traditional models in the context of colonialism. For example, Quaiser (2001, 317) provides an insight into the historical developments of the IMS:

*The doctor and Doctory ilaj (modern medical treatment) emerged as powerful symbols of colonialism and the colonial state. The doctor was the most visible representations of European knowledge; he looked, dressed and spoke differently. He was certainly not the hakim (a practitioner of Unani, the Graeco-Arabic science of medicine). The doctor with his stethoscope created*
an aura and mystery around himself; he symbolised modern medicine. In fact being visited by a doctor became a symbol of high status and modernity.

Colonisation has impacted people’s lives in the Indian sub-continent in many different ways (Brah, 1985). The emergent post-colonial literature has described the negative impact of this colonisation and the way the British curriculum was imposed on the colonised. One such testimony is *Unbecoming Daughters of the Empire* edited by Chew and Rutherford (1993) in which women from the ex-colonies articulate the long term impact of colonialism and how the curriculum and language medium of the schools consistently aimed at erasing their identities. Deshpande (1993, 103) in her reflective biographical account *Them and Us* analyses such an impact and illustrates in detail what it was like for her and many others growing up during the colonial period. She states:

> Perhaps it was the enormous colonial blinkers we wore that blanked out the rest of the world. There was only England and India. Them and us. And though there were pockets in India where the British did not rule—the Native States—it seemed that They were everywhere.....Actually, there were scarcely any English sahibs or memsahibs in the small town in which we lived. True, we did have a ‘King Edward V111 Park’ in the centre of town, and a maidan, the centrepiece of which was a hideous monument called ‘Thackerey’s tomb’, but ‘the English’ were a remote entity. Yet the idea of the empire somehow seeped into us, colouring our lives, giving them a distinctive tinge. It was all around us, most strongly in the English school we went to, where we did sums that went ‘John has 10 apples and Tom has five’, learnt poems about strange things like tuffets and muffins, daffodils and daisies.

Similarly, Linblad (1993, 126) points out how being brought up in colonial India led to acquisition of hybrid identities. She describes her experience of coming to the UK for higher education:

> For the first time the world outside corresponded to the world I had been reading about.
Bhabha (1994) describes hybridity as a fusion resulting from two relatively distinct cultural forms, styles and identities, creating a discursive space that he regards as a third space. It is within this space that competing representations of identities such as ‘local-global’ are constantly negotiated. Ang (2003) advocates for hybridity as a necessary concept to hold onto for it foregrounds complicated entanglement rather than the separateness and virtual apartheid experienced in the formation of identity. Ang (2003, 147) adds:

> These encounters are not always harmonious or conciliatory; often they are extremely violent, as the history of colonialism has amply shown. But even in the most oppressive situations, different ‘peoples’ who are thrown into intercultural confrontation with each other, whether by force or by will, have to negotiate their differences if they are to avoid war. The result, after many centuries of contact history, is a profoundly hybridised world where boundaries have become utterly porous, even though they are artificially maintained.

As the migration of Indians is not a new phenomenon, their integration into British society has been also been an area of interest among scholars, even when the numbers were very small. Bhabha (1994) refers to the Theory of Mimicry, whereby some Indians and Africans (the colonised) imitated the language, dress, politics, or cultural attitude of the British (the colonisers). This is seen as an opportunistic pattern of behaviour in which an individual copies the person in power so as to have access to that same power within the context of colonialism and immigration. Lahiri (2000, 62) states that this theory can be reworked to apply to a specific historic moment, and draws on a historical case in 1899 where an Indian student, Wagle, apprenticed himself to a factory in Britain to study the British glass industry. In combating enormous hostility based on his race and middle class status Wagle learnt that the greatest hostility he faced was due to his class and came from the factory workers, rather than from the factory owners, with one working telling him that ‘We hate all gents the same’. He therefore decided to integrate ‘not in gentleman’s clothes but as a fellow workman’. Adopting a cosmetic change and using phrases such as ‘old chap’
‘chappie’, shaking hands, acquainting himself with the workers’ home lives, and being aware of what was acceptable and unacceptable in that distinct working class culture helped Wagle to eventually become accepted. Lahiri (2000, 62) comments on this outward assimilation:

Wagle camouflaged his appropriation of imperial knowledge by adopting a mask of assimilation. But this time mimicry is relocated, away from the colonial periphery to the metropolitan centre, Britain, and the new class dimension causes Wagle (the colonised) to mimic British working class, metropolitan culture rather than middle class, colonial culture.

Doctors in this study are also an elite group of migrants, and those who have worked as GPs occupy who have a unique role in terms of their intimate relationship with their local communities. This study explores the strategies that they employed to overcome challenges in becoming accepted by the white working class patients they attended in rural and inner city deprived areas.

Allen and Smith (1974) contend that the Asian migration presents contrasting experiences in terms of class and refer to the class position of Asian doctors despite the structural constraints on Asians and the racist processes present in the professional occupations. For instance, the authors refer to the study of Gish and Robertson (1969) which found clustering of Asian doctors at the lower ends of various medical hierarchies and specialties. In spite of these processes, the authors argue that the Asian doctors relate to the class system as middle class individuals and demonstrate towards others, the class character of their occupation. In their life style and life chances, they constitute an elite; however, their training and class position in the UK is derived not from the British definition of class or the structural constraints imposed on Asians, but rather from the countries of origin. The interviews carried out in this study show examples of this which will be discussed in the
empirical chapters. Since, class may be an important determinant of community cohesion it is important to refer to the class structure of British medicine which I will discuss next.

Abercrombie and Warde (1993, 265) contend that the economic and social requirements of British society lead to the creation of disadvantaged positions within the class structure, and that the racism of British society ensures that black people continue to fill such positions to maintain the status quo. Navarro (1978) provides a detailed historical perspective of deep seated class inequalities in medicine in Great Britain, a thorough understanding of which shows how much power is held by consultants. The author emphasises that the division of labour and the specialisation in medicine that is produced via education and research, licensing and regulation with the help of state intervention, strengthens and legitimises a hierarchical order which already exists in our societies, and is based on the distribution of power relations along class, sex and race lines. Furthermore, the distribution of responsibilities of teams where upper-middle class extracted physicians sit at the top and nurses, who are pre-dominantly women, and are at the bottom of medical hierarchy, is primarily related to their class background as well as sex roles, with technological knowledge being only secondary to such roles. Navarro illustrates examples of how the class difference contributes to inequalities in service provision. For example, hospitals, which are regarded as workshops for consultants, have priority over General Practice and receive far much more expenditure than do the services of GPs. This is further evidenced by the fact that teaching hospitals are referred to as the ‘cream’ and have priority over non-teaching hospitals. An example of this inequality is provided for the period 1963-1969 where non-teaching hospitals, despite the fact that they had a heavier patient-load received less capital expenditure than the teaching hospitals (Navarro, 1978, 90). Navarro adds that one possible explanation for this inequity is that the non-teaching hospitals had more working class and elderly patients, whereas the teaching hospitals had middle-class and younger patients. Similarly, regional differences in the distribution of
services are based on the social class of the individuals in communities, the higher the percentage of working class residents, the lower the availability of consultants and General Practitioners in the area.

A further example of inequality provided by Navarro was the secretive system of awards whereby awards were given to consultants and once awarded, given, led to financial rewards for life. Navarro (1978, 43) argues that such a practice was purposeful and a way of the class-conscious Royal Colleges ensuring that there would not be equality within the system of rewards to different branches of medicine.

Raghuram et al. (2011) also discuss the clustering of South Asian doctors in geriatrics medicine in their research, which the authors argue is related to the disadvantaged positions of both, older people and the migrant doctors.

Since, individuals do not occupy a ‘single, easily stated, unitary identity’, intersectionality theory seeks to understand the complex ways in which ‘the great axes of social differentiation’ such as gender, class, race, ethnicity, disability and sexual orientation intersect, (Delgado and Stefancic, 2012). Vincent et al. (2012) middle class parents with a Black Caribbean heritage that explored their educational strategies and how these parents’ classed and raced identities shaped their interactions with school staff. The authors concluded that despite having the advantages of their class position in determining their and their children’s experiences as they endeavoured to bring about educational success, the degree and extent of the labour necessitated by Black parents in their interactions with schools, and the uncertainty of success, actually speaks to the ongoing significance of race and racism. This study can add knowledge as to what strategies the elites in this study employ to negotiate their raced and classed identities.

According to Lupton (2012), nearly all theorists on the doctor-patient relationship have described the way in which powerful groups in possession of medical and scientific
knowledge have been privileged over others. The concept of intersectionality is a useful tool to explore how privilege and disadvantage interact in different contexts such as this thesis which is focusing on the experiences of elite migrants.

2.3.3 Summary

This review has identified a knowledge gap in a number of areas in relation to the Community Cohesion Framework. The quantitative methodology and the indicators used to measure community cohesion are deemed inadequate. The review has pointed to the heterogeneity of ethnic communities, and the significance of place, while the fact that individuals have both ethnic and non-ethnic identities has also been acknowledged in the shaping of national and transnational identities. The community cohesion debate invokes discussions around identity, a sense of belonging to Britain, common values, and the contextual impact on one’s identity; however, it is not known how the experiences of overseas-trained South Asian doctors as an elite group of migrants relate to such discourses, how they negotiate the labour market, experience structural integration, and what types of social capital they utilize in such processes.

This thesis will explore the nature of social interactions of the doctors in the study with the wider society. The doctors are an interesting group to study because of their characteristics as an elite group of migrants and professionals. They are unlikely to face the same communication barriers their low/semi-skilled counterparts may have, and are most likely to be drawn from higher strata than the above group. This study can therefore provide empirical evidence as to how these elite migrants, who are privileged and marginalised simultaneously by their class position and migrant status experience their multiple identities such as place identity, British identity, class identity, hybrid/diaspora/transnational identity, and how these identities may intersect with each
other and how in different contexts different identities may become more salient than others.

Firstly, in order to understand more about the context and role of the overseas-trained South Asian doctors, it is important to have an awareness and discussion of the historical perspectives of their migration trajectories which is discussed in the following section discusses.

2.4 Historical Perspectives on the Migration of Overseas-trained South Asian Doctors

Following the creation of the NHS in the UK, which resulted in the expansion of the health workforce in 1948, a significant number of doctors came to the UK from the British ex-colonies. This was a result of an active recruitment drive by the UK government aimed at alleviating the critical labour shortage in terms of medical manpower, something which became a theme in subsequent recruitment policies (Doyal et al., 1980).

The earliest study of medical migration into and out of Great Britain was published in 1968 by the Ministry of Health. According to this study, the overseas-doctors represented one-fifth of all doctors in the UK in 1966 with 60% of all 14,500 foreign-born doctors coming from developing countries, the largest number (44%) of all of them being from the Indian sub-continent (Gish, 1969a; Gish, 1969b; Gish, 1970; Gish, 1971).

Gish’s work on medical migration in the 1960s was pioneering in that it provided a comprehensive picture of medical migration to, and emigration from, the UK and their possible determinants. In a briefing paper prepared for the Institute of Race Relations, *Britain and the Immigrant Doctor* Gish (1969b) draws attention to the dependency of the NHS on overseas-trained doctors this appears to be the earliest of such attempts to acknowledge the significance of the contribution of these doctors. Gish (1970) noticed a strong correlation between the numbers of British doctors emigrating leading to an increase

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3 It has subsequently been called as the ‘Department of Health and Social Security’ and ‘Department of Health’.
in the number of overseas-trained doctors in the UK. Gish also pointed out that the migration of UK-trained doctors included Irish migrant doctors was probably due to the fact that these doctors were unable to secure a senior hospital post combined with their unwillingness to enter General Practice.

Gish also highlighted the uneven deployment of overseas-trained doctors in various medical specialties and identified the barriers that overseas-trained doctors confronted when accessing the popular training posts in teaching hospitals. Gish and Robertson (1969) refer to the clustering of Asian doctors at the lower ends of various medical hierarchies in the least prestigious hospitals and in ‘unfashionable’ specialties such as geriatrics in the context of racist processes present in the professional occupations. The above report provides evidence that changes were introduced in the Commonwealth Immigrants Act at the time to accommodate the government’s strategy of encouraging overseas-trained doctors to come to the UK.

Following Gish’s studies, the publication of work of by Mej’ia (1978) concerning physician and nurse migration in the late 1970s is considered a landmark study as it incorporates data from more than 40 countries, presenting a detailed analysis of the flows and stocks of the physician and nurse workforce from these countries. The primary objective of the study known as The WHO Multinational Study was to identify what patterns of physician and nurse migration existed and to propose alternative measures with respect to each. The study refers to the migratory movement of physicians and nurses as ‘significant, currently unpredictable, and largely uncontrolled movement’ thus causing uncertainty in the planning of health manpower, particularly in the forecasting of future health labour requirements. The report provides an in-depth analysis of the characteristics of the migrants, the scope and directions of migratory flows, the reasons and for consequences of migration, and the actions taken by countries to regulate migration. The report acknowledges concerns that exist about a migratory flow of the elite from
developing countries flooding into a few privileged countries of the world; the effect of such movement relates to the assumed widening gap between rich and poor nations. The study reports that there were around 9000 medical migrants in the UK in 1970, Asia being the main donor. It draws attention to the significance of past colonial, language and cultural ties in migration patterns and directions from Commonwealth countries such as the Indian sub-continent.

The report describes reasons for migration in the context of ‘push-pull’ theory which was the prevailing theory applied at the time. This theory implies that innovation is most likely to occur when a need and a means to resolve that need are simultaneously recognised (Zmud, 1984, 727). Push factors have been a central component of the analysis of health-worker migration (Bach, 2004). These relate to seeking an improvement in one’s professional and financial situations, while pull factors relate to instances such as developing countries producing surplus to their need. However, Mejíia also refers to broader pull factors such as the language of tuition in medical education, suggesting that and those taught in English are likely to go to English-speaking countries, as well as the fact that the education and training they receive will have little relevance to the health needs of the majority of people in their country of origin.

Mejíia also commented on the role of the government in being more successful at fostering rather than hindering health worker migration, and arguing that restrictive measures merely served to postpone or divert migratory movements. Apart from quantifying the stock and flows of physicians and nurses between donor and recipient countries, Mejía’s study was also concerned with the policy implications of migration, it makes the recommendation that the self-interest of developed countries can only be tenable only if they incorporated a growing enlightened regard for global interest.
In subsequent years, the data collection regarding overseas doctors took place in the context of discussions in order to ensure that the NHS workforce had the right number of doctors at the right place and the right time. Different studies provide different accounts as to exactly how many such doctors came to the UK. Smith’s (1980) study refers to the DHSS statistics, stating that more than one third (40%) and one fifth (20%) of the medical workforce were doctors and GPs (respectively), who had trained overseas. According to Doyal et al. (1980) 14% of GPs were overseas-qualified. Robinson and Carey (2000) found that in 1995, 32% of all NHS staff were born outside the EU, while in 1980, 14% of NHS doctors came from the Asian subcontinent. Jones and Snow (2010, 35) describe this period as follows:

*Within twelve years of the creation of the NHS, Manchester was growing increasingly reliant on overseas junior staff for the day-to-day running of its hospitals, while doctors from India and Pakistan were shoring up the city’s GP and dental practices.*

Doyal et al. (1980) argue that the presence of overseas doctors in the UK has stimulated ‘discussion’ and ‘controversy’. Ironically, the earliest of the studies do not seem to discuss the type of jobs these doctors occupied, their career prospects or the relevancy of their post-graduate training to their needs (Anwar and Ali, 1987). Rather, these debates appear pre-occupied with two interrelated themes. Firstly, the recruitment of overseas doctors was explained in the context of the ‘Brain Drain’, that is the loss of doctors to richer countries, which paid limited attention to the implications of sending expensively trained migrant doctors outside their poor countries whereas the second debate was concerned with the professional competence of overseas doctors (Doyal et al., 1981).

The remaining literature generally relates to the contribution of overseas-trained doctors working in the NHS, their experience of racism and the implications of the gap created by their departure, for example, retirement, which will be discussed under sub-headings. In order to understand how overseas-trained South Asian doctors came to put down roots in
UK society, an important first step is to explore is the context of their migration, and the theoretical framework that informs such migration, before looking at an overall settlement pattern.

2.5 Migration Theories

Migration studies claim that migration results when various forces interact with each other on a ‘migration axis’ - these forces are classified as ‘push’ and ‘pull’ factors and they can be economic, legal, historical, cultural, social, and educational (Mej’ia et al., 1979). The factors present in the donor countries are regarded as ‘push’ factors, as the name suggests pushing individuals to move to another area, urban to rural or vice versa, or even to another country. Samers (2010) argues that causes of migration can be found in the cultural, political and social marginalisation of specific groups of people. Raghuram et al. (2010, 626) also cite examples where interviewees in their study described ways in which their social capital was limited in the pre-migration scenario and thus likely to have spurred migration. The authors argue that this was a particular form of social capital that could not be acquired through education or qualification within the context of regional, class and caste politics shaping South Asian medical labour markets, therefore making it difficult to obtain jobs in South Asia. The above aspect was also referred to by interviewees in this study and is discussed in section 7.4. The ‘pull’ factors correspond to receiving countries, and may relate to attractive features in that country. Kline (2003) undertook an analysis of the push and pull factors of nurse migration and found that such factors were related to economic and social forces.

Push-pull theories have been influential in sociology, however, they have also been considered as inadequate as they include a model that places emphasis on micro-level structures without incorporating historical perspectives (Castles and Miller, 2003; Samers, 2010).
In order to gain a fuller understanding of ‘skilled international migration’ Robinson and Carey (2000) argue that we need to ‘unpack’ such typology and redefine in a way whereby it becomes an inclusive experience. The authors contend that migration is an act of human agency which needs to be understood on two different levels, *discursive consciousness and practical consciousness*. They draw on the work of Giddens (1984) and add that discursive consciousness refers to what actors are able to verbalise about social conditions of their own action, and can be measured through questionnaires. Practical consciousness is about what actors know of their social conditions, but cannot articulate discursively. Robinson and Carey refer to their own qualitative study of the migration of Indian doctors to the UK which showed that their migration, at a discursive level, may appear to be related to an economically driven factor; however, on the level of practical consciousness, it was observed to be a phenomenon that was imbedded socially, culturally and historically. They argue that the researchers theorised the causes of migration within a behaviouralist paradigm while applying positivist methods which concern measureable and observable ‘events’ prior to and following the act of migration. They advocate for the application of qualitative methods which allow effective probing and the discussion of experiences in a reflective and introspective way. In order to comprehend the intricacy or multifaceted nature of the explanations that may exist for the pattern of the migration by this elite group, I used qualitative research and conducted in-depth interviews in the interviewees’ first languages.

Robinson and Carey (2000) contend that there are parallels to be drawn between skilled and unskilled migration and that the connecting key elements include colonial and post-colonial ties between two countries, the tradition of people migrating from India to Britain, and the notion of *Izzet* and racism within the NHS. *Izzet* relates to acquiring material belongings and social standing such as honour and status. Robinson and Carey’s study raises some interesting issues that have not been explored previously; however, its small
sample of nine Indian doctors is not representative of the diversity of experiences of the vast majority of overseas-trained South Asian doctors. These qualitative features were explored in considerable detail in this study with a larger sample, and the results discussed in empirical chapters 5-8.

Building on the work of scholars such as Esmail and Robinson and Carey, who have referred to the role of British colonial presence in the migration process of overseas-trained South Asian doctors, Migration Systems Theory appears the most comprehensive theory to explain the migration of overseas-trained South Asian doctors. This is because it incorporates all dimensions of the migration experience, via an interdisciplinary approach. This theory assumes that migratory movements result from the interaction of macro-, micro- and meso-structures, allowing an enhanced understanding of why the binding apprenticeship between migrant labourers and Britain continued to exist until well after the fall of the empire (Castles and Miller, 2003, 27).

Increasingly, transnational theory has also attracted attention over recent years, as worldwide transportation and advanced telecommunication technologies have played a role in facilitating movement between two or more social spaces or places, therefore blurring the similarities of social and geographic space (Castles and Miller, 2003). As a result of this shift in migration patterns, the question of migrants’ performance in the UK has been increasingly raised as a matter of concern, for identification with one’s country of origin is perceived to impact negatively on one’s sense of belonging and identity to a new country (Basch et al., 1994). The community cohesion framework appears to view such links negatively. For example, Denholm (2010, 10) reports a working group’s progress in relation to community cohesion in NHS Scotland and states:

*Modern communications can work in the opposite direction to integration, by providing the opportunity to maintain external frames of reference that reinforce cultural heritage, rather than the ‘bridging’ of cultural divides.*

Snel et al. (2006, 5) point out that in fact both identities can co-exist:
...a strong transnational involvement of migrants and integration into the host country, do not rule each other out.

Vertovec (2002) argues that previous researchers have been pre-occupied with the concept of migrants’ adaptation to their new place of immigration, and have played less attention to how migrants maintain links with their countries of origin. This thesis will add knowledge in this area and explore whether the doctors in the study have transnational links and what the implications of such ties are for their integration process in the UK.

In the following sections, I will review specific studies that have been undertaken in the UK relating to the post-migration experiences of overseas-trained South Asian doctors in the NHS.

2.6 The Role of Overseas-trained South Asian Doctors - Controversies and Contribution

Smith’s (1980) study was the first comprehensive study undertaken which provided statistical and historical background to the migration of overseas doctors and offered a survey of the presence of overseas doctors at the time. The study was commissioned as a result of The Merrison Report (1975) in which concerns regarding the competencies of overseas doctors were stated. It consisted of a cross-sectional survey of a sample of 1,981 overseas and UK-trained doctors and compared the experiences of both groups in the context of their career histories. Issues such as why the doctors decided to remain in the UK or return to their home country or migrate to another country, their views on the fairness of selection procedures within the hospital and General Practice, and the type of professional relationships existing between the two groups in the study, were examined. Almost one third of the survey population (31%) of doctors was born overseas, and the largest group among them was from the Indian sub-continent. The study reported that overseas-trained GPs were older than the British GPs, which was due to the fact that the overseas doctors had been practising for some years in their country of origin prior to their
migration to the UK. The analysis showed an uneven geographical distribution of overseas-trained doctors in comparison to the UK qualified doctors. The North West area of the UK had the highest (40%) proportion of overseas doctors, whereas the South West area had the lowest. The overseas-trained GPs tended to be concentrated in regions that were ethnically dense, raising questions as to whether this pattern related to their informed choice or was the only available opportunity. Overseas-trained women doctors, in general were less likely to migrate for reasons other than family reunification, however, two-thirds of the women in the survey did migrate to the UK for reasons related to their own careers.

Despite the fact that the NHS adopted a policy of promoting group General Practices to ensure provision of a more inclusive service, 22% of overseas-qualified GPs in the study were working in single handed practices compared with only 10% of British-trained GPs. The survey was unable to offer any explanation as to why this was the case. It is possible that they were not able to find jobs in group practices as a result of discrimination or they may have wished to be independent and entrepreneurs in their own right. The study did not find any significant language problems among senior registrars and GPs. Overseas-trained GPs tended to have a higher postgraduate qualification in a specialty other than General Practice which suggested that the majority did not intend to have a career in general practice. The study reported that 72% of the UK-trained general GPs believed that some patients were resistant to seeing ethnic minority GPs, something which the overseas-qualified GPs tended to be unaware of. The UK-trained GPs also tended to criticise the communication skills of overseas-qualified GPs in relation to patients and other doctors. Overseas-trained GPs had, on average, to make twice as many job applications compared with their British qualified counterparts, despite the fact that they had higher qualifications than the British-trained GPs.

This study raises a number of useful questions regarding the overseas-trained doctors’ own perception of their competency issues, over-representation in single handed practices,
uneven geographical clustering, experiences of racism within the NHS, and the overseas-trained doctors’ relationships with their patients, in particular, white patients. The proposed study will attempt to explore what perceptions overseas-trained South Asian doctors have of their mobility in the NHS in terms of working conditions, career development and of their contributions to the NHS.

A study undertaken by Taylor and Esmail (1999) highlights the contribution of overseas-trained South Asian GPs and how their retirement was likely to create acute recruitment difficulties in areas described as relatively deprived practice populations. The results were used to project the numbers who were likely to retire by 2007 and determine the impact of their retirement. The study provides a useful breakdown of health authority areas where overseas-trained South Asian doctors were clustered; however, individual ethnicities within the South Asian cohort are not differentiated, something which this study investigates, as well as the doctors’ contributions to the communities that they served.

Esmail (2007) provides a historical background to the migration of doctors from the Indian sub-continent in the context of post-colonial links, looking at how medical education in India has been influenced and controlled by Britain and suited to western medical practice. Esmail describes the inequalities experienced by the overseas-trained South Asian doctors while working in the lower status ‘Cinderella’ services of the NHS, for example, working as junior doctors or registrars, and asks why their position in the NHS has not been looked into in the same context as ‘indentured labour’. Esmail’s assertion is based on the research findings that overseas-trained South Asian doctors are more likely to work in specialties which are less attractive among white doctors, for example, geriatrics and psychiatry. These doctors are also likely to be working as junior doctors, with few reaching the position of consultants (Doyal et al., 1980; Smith, 1980).
Several scholars have commented on the positive attitudes of overseas-trained South Asian doctors while working in the least desired practice areas of Britain. Lahiri (2000, 61) draws on her research on Indians in Britain between 1880-1930 and states that the prejudices suffered by Indian students in Britain was due to the intertwining of racial and class prejudice. This was hard to separate in the Victorian era when no amount of talent could make an Indian ‘acceptable’. Lahiri argues that while the British medical establishment was less accommodating, and Indians were not allowed to climb up the hospital career ladder, they were accepted as private doctors. Lahiri states that Indian doctors did establish thriving practices and refers to their high measure of popularity among the miners and other classes of workmen in Scotland as early as 1919. Lahiri believes that such high levels of acceptance did not derive from their class background, but rather the positive attitudes and individual abilities of these doctors who had been forced to work in deprived areas, as well as their rapport with the patients in such communities.

Murfin and Hungin (1993, 139) contend that the fact that many practices in the coalmining, inner city and heavy industrial areas are served by Asian doctors is not some accidental phenomenon. They draw attention to the positivity of a negative outcome:

> Ironically, they often enjoy a close affinity with the community they serve, a perverse illustration that many graduates of British medical schools are not culturally particularly well suited to work in these areas of the UK.

Esmail (2007, 828) also refers to the value added contribution that these doctors made while working in poor areas of Britain:

> It is also true that many doctors were also probably influenced by the Ghandaian philosophy of service to the benefits of humanity without personal rewards. This is perhaps why many doctors also ended up in deprived areas and became involved in local politics.

Bhopal (2008, 98) adds that the overseas-trained South Asian doctors’ concentration in psychiatry and geriatrics may be owing to socio-cultural perspectives rather than the
doctors’ actual understanding of the competition for such posts. Dorling (2009, 60) discusses the potential benefits of having a more internationally experienced and better skilled health workforce in the context of the likely implications of British social class divisions stating:

*Working class people are often talked down to by middle and upper class doctors. Such doctors often resent the kind of work they find themselves doing. When they applied to go to Medical School it did not cross their minds that they might, later, be asked to work with sick people all day. A better skilled medical workforce would provide a far better resource for working class people. Medical staff who come from abroad are less likely to see people in Britain as beneath them.*

Dorling refers to the study by Greenhalgh et al. (2004) which set out to investigate the perceptions of 14-16 year olds from different ethnic and socioeconomic backgrounds and to understand the wide socioeconomic variation that existed among applicants applying for medical school places. The findings revealed that stereotypical and superficial perceptions of doctors were prevalent among pupils from lower socioeconomic groups who viewed medical schools as institutions that were ‘culturally alien’ to them and more suited for students coming from ‘posh’ backgrounds, therefore misjudging their own worth and chances of successfully gaining a place and continuing at course in medicine. Dorling’s assertion that overseas doctors are less likely to see people in Britain as beneath them and the anecdotal evidence suggesting the popularity of overseas-trained south Asian doctors merits an investigation into whether overseas-trained South Asian GPs practice medicine in a particular way.

This section has discussed studies relating to the role of overseas-trained South Asian doctors. Several concepts have been identified as important themes in the above studies which this thesis will explore further. They include the distribution of these doctors in the NHS and how patterns of inequalities observed by Smith have persisted over the years.
Studies have also referred to a more positive contribution made by these doctors in relation to the provision of healthcare while working in the least desired practice areas of Britain. This thesis will additionally explore doctors’ own perceptions of their social mobility and their relationship with their patients and communities.

2.7 Experiences of Racism in the NHS

Evidence suggests that all migrant workers are exposed to some form of prejudice by individuals and institutions. The experiences of Irish nurses (Ryan, 2007) and West Indian nurses (Baxter, 1988) are well documented and echo similar discriminatory experiences as do the reports of Jewish doctors. Grunwald-Spier (2010, 171) also refers to the experiences of Jewish doctors in 1938 when Jewish migrant doctors were met with ‘obstinate resistance’ by the British medical profession.

In this section, I will discuss those concepts that have been identified in various studies specifically undertaken with overseas-trained South Asian doctors concerning the experiences of racism.

Various scholars such as Smith (1980), Anwar and Ali (1987), Esmail and Everington (1997), and Esmail (2007) have drawn attention to the structural inequalities embedded in the NHS and that overseas-trained South Asian doctors encounter. Apart from direct and indirect racism, The Commission for Racial Equality defines racism in terms of attitudes and ideology (Solomos, 1993). Esmail refers to this inequality as a legacy of imperialism and ‘indentured labour’.

Doyal et al (1980, 12) also argue that overseas doctors, in reality, fill the least prestigious post of junior doctors, which usually has the least adequate training element, hence enabling British graduates to occupy the preferred training posts. They are also critical of the exploitive approach adopted by Britain stating that:
The employment of large numbers of overseas doctors is often justified on the grounds that they occupy ‘training posts’ and that this therefore provides a form of British aid to the third world.

Doyal et al. (1981) argue that such workers play a vital role in sustaining a major social service and regard the above as an ‘epidemic of national chauvinism’ cultivated by the then Conservative government. They contend that reports like The Merrison Report discussed previously only serve to reinforce the claims to supremacy made by a British medical education, and make working in a British hospital even more attractive for prospective overseas doctors. They argue that the training received by these doctors has little relevance to the health needs of their own countries and draw attention to the various ways that Britain benefits from the continuous supply of overseas-trained doctors. For example it is cheaper to employ an overseas doctor than to train one in this country. The complexities involved in the migration process of overseas-trained South Asian doctors will be explored in this thesis adding to the knowledge related to the perceptions of the doctors in the study.

As the issues of persistent staff shortages of UK-trained doctors were being addressed in the 1970s, increasing concerns were also being expressed about the professional competencies of overseas-trained South Asian doctors; these were formally expressed in The Merrison Report of 1975, as stated previously. The study by Smith (1980) also highlighted numerous problems faced by overseas-trained doctors, for example, some were not able to obtain full registration with the General Medical Council as they qualified from certain medical colleges that were not recognised as valid, there were language issues, overseas-doctors were not able to obtain the training they had anticipated they would obtain upon arrival in the UK, doctors were not given the freedom to choose their specialty etc. These concerns led to the birth of the first overseas organization, the Overseas Doctors’ Association (ODA) that was set up to address the above issues.
However, Smith (1987) points out that while it cannot be denied that overseas-trained doctors face disadvantages when competing for NHS jobs, it is not crystal clear whether this discriminatory practice relates to the adequacy of the doctors’ training, their competency, and their ability to speak English or if it is based on the grounds of race. Despite the fact that many overseas-qualified doctors claim to be racially discriminated against, lack of ‘irrefutable’ evidence poses dilemmas for researchers and consequently has long remained an excuse for non-action (Smith, 1987).

Anwar and Ali’s (1987) study covered similar issues to Smith’s, however, the former included the experiences of ethnic minority doctors trained in the UK, as well as ethnic minority overseas-trained doctors. The study revealed that the predominant reason for migrating to Britain cited by 60% of the overseas-trained doctors was to gain further qualifications, 18% came to acquire a fellowship, and 12% came to gain experience. The study confirms previous findings in relation to the unequal treatment of overseas-trained doctors. For example, overseas-trained doctors were found to be concentrated in non-teaching hospitals rather than teaching hospitals, and in unpopular specialties, for one in three doctors, the specialty they were working in was not their first choice. In relation to the number of job applications made, though there were similar patterns between both the ethnic group doctors trained in the UK and those trained overseas, as both groups had to make more applications than the UK-trained doctors, this difference was starker for the overseas-trained doctors.

It is interesting to note a discrepancy in the way the doctors responded with regard to their perception of the relationship existing between ethnic minority and white doctors. A ‘friendly’ relationship with their white counterparts was stated by 20% of ethnic minority doctors whereas only 11% of white doctors believed this to be so. The white doctors were less likely to say that outside working hours, they ‘frequently’ mixed socially with their ethnic minority counterparts. In relation to asserting they experienced ‘No discrimination’,
26% of white doctors said there was no discrimination, in comparison with 8% of ethnic minority doctors.

The study makes a valuable contribution, and adds to our knowledge in the area of personal and professional experiences of overseas-trained doctors; however, it also raises questions as to its validity. The respondents were self-selected, the white British qualified doctors were older than the other two groups, and the number of respondents was small. The study often did not distinguish between the experiences of British trained white, and ethnic minority doctors also trained in Britain which it set out to achieve.

Earlier studies have a tendency of perceiving the problems in the context of structural inequalities rather than institutional racism. However, in the 1990s, studies began to emerge which showed that racial discrimination was a widespread feature within the NHS and that it impacted on individuals at several levels. Two studies conducted by Esmail and Everington (1993), and Esmail and Everington (1997) explicitly state that doctors from ethnic minorities were experiencing racial discrimination. The studies used randomised experiments using CVs and investigated whether the UK-trained doctors with Asian names had equality of opportunity with their white counterparts at the shortlisting stage. The findings showed that the doctors with Asian names were less likely to be shortlisted for senior house officers’ posts. In a repeat study that occurred five years after the first study, Esmail and Everington (1997, 1619) reported that despite numerous commitments by the NHS, discrimination remained rife. Other areas where evidence suggests the prevalence of racial discrimination is in the allocation of distinction awards to consultants (Esmail et al., 1998) and the disproportionately high number of complaints against made against overseas doctors (Esmail and Everington, 1997).

‘Racism in Medicine’ edited by Coker (2001) adds to our knowledge in relation to the experiences of overseas-trained doctors as well as British trained South Asian doctors,
experiences which are often not so dissimilar to each other. The book explicitly discusses
issues of racism and harassment experienced by overseas doctors and covers pertinent
issues such as racial discrimination in medical schools, racial harassment within the NHS,
career progression and job satisfaction and identity and belonging, all which continue to be
important contemporary issues. Dadabhoy (2001), a British born South Asian doctor gives
an account that shows that doctors from ethnic minorities who are born and trained in the
UK are not immune from discriminatory treatment.

Against The Odds by Jones and Snow (2010) is the most recent addition in our knowledge
regarding the contribution of BME clinicians in the Manchester area, covering the period
1948-2009. It provides an historical view of the experiences of the nurses, health visitors
and doctors recruited from overseas; however, the focus of research is exclusively on the
Manchester area. The findings of the study corroborate earlier results in relation to the
career structure and the challenges faced by health professionals. The authors highlight
racism as a common experience among doctors from a BME background; however, the
British trained South Asian doctors were less likely to report experiences of direct racism
than their overseas-trained counterparts. The authors noted that the respondents rarely
talked about racism, however, when they did, this often related to others’ experiences
rather than their own.

The tendency South Asian doctors to underrate experiences of racism occurring within the
NHS by is well documented in an article ‘Don’t Mix Race with the Specialty’ by Bornat et
al. (2009, 74). Here, the authors discuss the challenges faced by researchers in the course
of analysing diverse oral history data, and show how they used a multiple layered analysis
to seek insight into the experiences of racism where the issue was ‘identified, silenced or
subsumed’. The study involved over 30 interviews with South Asian geriatricians with a
view to exploring their role in the development of geriatric medicine.
The anecdotal evidence suggests that overseas-trained South Asian doctors were subjected to cultural racism. For example, Coker (2001, 7) refers to comments made by a German doctor when referring to overseas doctors:

*If only they dressed like us and sounded like us and behaved like us, it would be so much easier to not think of them as foreigners.*

Coker (2001, 7) discusses the dilemma posed by the binary opposition of integration and marginalisation and how the doctors have had to deal with such issues referring to a quote by a black doctor:

*Remaining at the margin and being critical of the system may be attractive, but it will paralyse the process of change.*

The above statement echoes the determination of many migrant doctors who did not allow the above experiences to overwhelm and marginalise them. It is within this context that the proposed study aims to add knowledge and offer ground-breaking assertions, in the sense that the experiences of overseas-trained South Asian doctors in the context of community cohesion have not yet been previously explored. There remains little research available that relates to the personal experiences of overseas-trained South Asian GPs who have worked in areas that are pre-dominantly white; and sometimes they were working in rural areas where they may have been the only Asian person. There are some interesting biographical accounts such as *I Made My Home in England* written by the wife of Indian origin General Practitioner Savariti Chowdhary (1954) in which she states that she never experienced a single incident when she felt discriminated against. However, she also describes at length how she camouflaged herself to fit in, for example, cutting her waist-length hair, speaking English at home, dressing in western-style clothes and wearing ample make-up so as to not look too conspicuous in the village. She also describes how her husband ceased to be a strict vegetarian which was a requirement of his Hindu faith, however, he did perform
Hindu wedding ceremonies as a Hindu priest, a new role that he had taken on in reply to a need that had arisen their small size Hindu community.

Recognising the limitations of previous studies, this thesis will explore issues related to social as well as professional lives of overseas-trained South Asian doctors and incorporate the principles of ant-racist research by Dei and Johal (2005) in its approach. The authors argue that anti-racist researchers need to acknowledge that the voices of subjects are likely to have been somewhat polluted and affected by centuries of oppression. Dei and Johal (2005, 257) emphasise the significance of how these voices are interpreted:

But that interpretation has to be done with, rather than for, the people in a space that is safe, free, and sensitive to the power relationships involved.

The authors state that how the researcher frames his or her questions is critical in shaping the subjects’ understanding of their experiences which may be gendered, and classed. I will discuss this further in Chapter 3 on how I implemented an anti-racist approach in this study.

The literature related to entrepreneurship clearly shows that immigrants seek self-employment in order to overcome blocked social mobility caused by racism at societal level, which can be evidenced in Zhou’s (2004, 1047) assertion below:

... racial exclusion and discrimination erect structural barriers to prevent immigrants from competing with the native born on an equal basis in the mainstream economy. As a result, immigrants either take jobs that natives do not desire or carve out market niches for themselves, meeting the potential demands for specific goods and services unmet by the mainstream economy.

In the following section, I will review the relevant literature in the area of entrepreneurship anecdotal evidence highlights the exhibition of the entrepreneurial behaviour of overseas-
trained South Asian doctors for entry into General Practice despite the fact that they are elite migrants.

2.8 Entrepreneurship

Ethnic entrepreneurship has been an area of interest for social scientists for a long while and much research and debate has enthused about this social phenomenon. Ballard (1994) regards migration itself as an entrepreneurship activity, whereas Zhou (2008) states that some immigrant groups and ethnic minorities are more likely to be entrepreneurs than others in the pursuit of socioeconomic mobility.

Most of the literature in the area of migrants as entrepreneurs has been written based on the experiences of manual or semi-skilled workers although Ballard (1994) acknowledges that not just peasants, but people with professional skills have migrated from India. However, Zhou (2008, 219) refers to the typical images that are conjured up in relation to who the entrepreneurs are:

_In the laymen’s eye, however, ethnic entrepreneurs often carry images of petty traders, dealers, shopkeepers or even peddlers and hucksters who engage in such industries or business as restaurants, sweatshops, laundries, greengrocers, liquor stores, nail salons, newsrounds, swap meets, taxi cabs and so on._

Bygrave and Hofer (1991) define an entrepreneur as someone who perceives an opportunity and creates the organisation for its pursuit. This effective strategy of circumventing labour market barriers is employed by ethnic entrepreneurs to move socioeconomically upwards in the host society (Zhou, 2004).

The significance of South Asian communities’ contribution to entrepreneurship in the UK and how it is determined, has been a subject of much discussion (Ward and Jenkins, 1984; Werbner, 1984; Kalra, 2000). Small retail shops, restaurants, and take-aways, have long
been associated with the socio-economic mobility of South Asians in Britain, alongside their cultural characteristics such as being industrious, relying on family and friends for cheap labour, and a desire for independence, all of which have been described as ideal for entrepreneurial activity (Mars and Ward, 1984). A small scale study undertaken in Manchester in 1970 showed that overseas-trained South Asian doctors were also constrained by their race and employed strategies of self-employment to circumvent the system that blocked their mobility in the NHS (Nowikowski, 1984) where they were restricted to the least desirable and poorly paid rungs of the medical occupational hierarchies (Esmail, 2007).

Though the concept of entrepreneurship has traditionally been discussed in relation to the lesser skilled sectors of the labour market, Raghuram et al. (2010) endeavour to expand the concept of entrepreneurship to the skilled sector. The authors undertook research with geriatricians of South Asian origin in the UK and found a clustering of South Asian doctors in geriatrics which is a marginalised area of medicine with a relatively high proportion of South Asian doctors. According to 2004 statistics from the Department of Health, the ratio of consultants among South Asian doctors and white doctors was 17:42 respectively (Raghuram et al., 2010). Esmail and Carnall (1997) and Essed (1991) consider this inequality as a result of the institutionally racist and hierarchical nature of the NHS. Geriatric medicine has also been seen as a ‘Cinderella speciality’ since its inception (Jefferys, 2000; Smith, 1980; Thane, 2002), for it treats a marginalised section of society, that is, older people who are deemed as one of the least regarded patient groups (Evans, 1988). Goldacre et al. (2004) contend that it was within this context that geriatric medicine became a refuge for overseas-trained doctors who were unable to make initial inroads into their preferred specialties. Raghuram et al. (2010) place emphasis on exploring the process of how networks operate between migrants and non-migrants and the need to look at them relationally rather than focusing entirely on migrants’ networks or on treating both groups
as separate entities. In particular, drawing on their own research analysis, the authors argue that it is crucial to explore how non-migrants’ networks may reproduce privilege shaping labour market opportunities for migrants. They add that it is the social capital possessed by the non-migrants that limits the migrants’ ability to convert their social networks into social capital. This research is able to build on the work of above authors and explore overseas-trained south Asian doctors’ reasons and processes of entry for General Practice.

Few previous researchers have considered overseas trained GPs as entrepreneurs in their own right. Apart from some autobiographical accounts such as by Sayeed (2006) little is known about how overseas-trained south Asian doctors have overcome some of the social, environmental and economic challenges of running practices which they either set up from scratch or which had been left vacant as a result of local doctors emigrating or wanting to work in less deprived areas. Nowikowski (1984) provides a detailed account of the historical structural inequalities linked with colonisation and argues that the emergence of businesses is a survival strategy applied by Asians in the UK to combat the disadvantage that they experience as a result of inherited positions of structural inequality. In her study of Asians, living in middle-class residential area in Manchester, and using survey respondents who were heterogeneous and included GPs, Nowikowski (1984) found that the Asian GPs had also adopted similar strategies to overcome structural barriers within the NHS. For example, where their mobility was severely restricted, they had chosen specialties that were less popular or did not involve hospital work such as General Practice, which allowed them to manage resources independently.

Jack and Anderson (2002) contend that considering an entrepreneur in isolation does not enhance our understanding of entrepreneurship, but that in order to enhance our understanding of the phenomenon, it should be regarded as an embedded socio-economic process. The authors use Giddens’ view of structuration as a theoretical framework for exploring the link between the entrepreneur (as agent) and the context (as structure) and
illustrate in their study that social structures do affect entrepreneurial activity. They argue that embeddedness in the social structure produces opportunity, enhances performance and enables entrepreneurs to use the particularities of their environment. They add that the role of the entrepreneur, conditions both recognition and realisation of opportunity in the social structure.

Hansen (1995) argues that entrepreneurs identify social resources as an essential step in the start-up of their businesses; therefore the concept of social embeddedness is significant to entrepreneurship. Jack and Anderson (2002) further argue that entrepreneurship must involve and draw on society if it is embedded in the social context. The authors argue that the social whole needs to be taken into account when examining the entrepreneur (individual/or agent) as this is paramount and beyond its individual parts (Cassell, 1993). They emphasise the significance of the context (structure) in which the entrepreneurship is embedded and state that the extent to which an entrepreneur is socially embedded and congruent with the structure is likely to affect their ability to draw on the social and economic resources of that structure, thus impacting on the nature of the entrepreneurial process and event. Drawing attention to the dynamic relationship between structure and agency, Jack and Anderson (2002) refer to their ethnographic study where respondents were providing something which they considered was needed by the local community, and which would be beneficial; but equally they drew upon the locale to support their business.

In seeking to understand the contributions of overseas-trained doctors in General Practice, it is important to explore their experiences in relation to concepts of entrepreneurship. Using the analytical lens of entrepreneurship, the types of social capital (bonding and bridging) and the social relations in which overseas-trained South Asian GPs are embedded, in particular, ethnically dense and poor white working class areas can be confirmed.
2.9 Summary and Conclusions

This chapter discussed the theoretical foundation of this thesis providing an overview of the dominant theories in community cohesion, migration of overseas-trained South Asian doctors, entrepreneurship and identities. Other concepts that evolved from this discussion include social capital theory and experiences of racism, which are both relevant to the research questions of this study.

The review has highlighted the need to update our quantitative understanding of the scale of migration, demographic characteristics and geographical distribution of overseas-trained South Asian doctors as previous studies are out of date, have little background detail on this population, and do not take into account recent changing patterns and policies around immigration. Hence, the first research question is concerned with structural integration and orientates towards investigating the proportions of overseas-trained South Asian doctors in the total UK GP workforce as well as exploring their demographics, key locations of employment and how this pattern changed over the period 1992-2009. It was considered important to explore the perceptions that overseas-trained South Asian doctors have of their own mobility within the NHS, in terms of working conditions and career development and of their contributions. There is also a knowledge gap in relation to overseas-trained South Asian doctors entering General Practice, and the structural, social and individual resources they employed in setting up GP practices and establishing themselves as GPs, which this study will explore. This knowledge is important as it can reveal the types of social capital utilised by this elite group of migrants.

The review of the community cohesion literature has highlighted a number of deficiencies, for example, the need for an appropriate methodology which is suitable for investigating the experiences of community cohesion such as in depth interviews. It has also shown that little is known about the nature and extent of the social roles played by overseas-trained
South Asian migrant doctors, therefore, this study is the first of its kind to investigate the integration experiences of elite migrants such as this group.

The community cohesion debates invoke discussion around identity, sense of belonging to Britain, common values, and the impact of context on one’s identity; however, it is not known how overseas-trained South Asian doctors relate to such discourses from their position as elite migrants, or whether stereotypes used in such debates necessarily apply to this group. In this section, I have discussed the theoretical framework which underpins the debates about identity which is likely to have a bearing on the identities of this elite group of identities. The literature in this area emphasises that identities are multiple rather than dichotomous. Identities are formed by social processes and produced in a dialectal relationship with society. I have discussed the sociological explanations as to how diasporas are formed, how colonialism has impacted on people’s lives and how social status and social class may impact on an individual’s identity and lead to contrasting experiences. I have also reflected on intersectionality theory which highlights the complexity of identity. The work of Raghuram et al. (2011) is of particular importance to this study as the empirical findings of their study highlight both the privileged position of overseas-trained south Asian doctors and their clustering in geriatrics medicine especially. However, relatively little is known of the experiences of overseas-trained South Asian doctors as elite migrants and this study can make a valuable contribution towards such debates.

Apart from the adoption of a mixed methodology, it is envisaged that a case based comparative study in three diverse areas will help us better understand the complexity of the spatial experiences of overseas-trained South Asian doctors. Therefore, the research question is related to the exploration of how different contextual factors have impacted on
the identities of overseas-trained South Asian and their perception of the communities around them.

The review has highlighted the significance of capturing the narratives of overseas-trained South Asian doctors and exploring what insights can be gained from the experiences of these highly educated labour migrants, and how these can contribute to debates concerning community cohesion in the UK. It is important to explore overseas-trained doctors’ own perception of their migration history, types of social networks utilised, relationships with other professionals and patients/communities, entry into General Practice, the extent of their integration into British society, the mediums in which they have made their contributions in health care and wider the society, their roles as potential entrepreneurs in the UK and their transnational roles. The review has established that exploration of their experiences in the context of community cohesion will highlight a different kind of contribution and is likely to challenge the orthodoxy of the views held in the existing community cohesion research in relation to minority communities in Britain.
Chapter 3: Methodological Framework

3.1 Introduction

This chapter provides a detailed account of the methodological framework that guided the research study. It will begin by describing the background to the study and the research objectives. I outline how research objectives called for a mixed method approach and explain the development of the appropriate research instruments to be applied. This is then followed by a detailed description of the research design including approaches and techniques that were applied in the study from the point of formulating the research design to data collection, analysis and interpretation.

3.2 Background to the Study

The aim of the research study was to gain an insight into the structural and socio-cultural integration experiences of overseas-trained South Asian doctors in the UK. The time period considered is the 1960s onwards as this encapsulates the era of their most significant migration into the UK and captures their professional and social experiences over a longer timeframe, that is, from early migration to settlement. A mixed method approach was considered appropriate that included secondary data analysis of the GP Workforce Statistics and in-depth interviews with 27 overseas-trained South Asian GPs in three different geographical locales in England which had varying ethnic populations.

3.3 Methodological Theory

As Harding (1987) has argued a useful distinction can be made between method and methodology. Whilst a method concerns itself with techniques for the gathering of research material, methodology is concerned with the theory and analysis of the research process.
In any social research, the decisions about how to study the social world, through the assumptions of ontology or epistemology, are two important aspects that are integral to deciding on the appropriate set of techniques. Ontological assumptions are concerned with social reality and what there is to know about the world (Ritchie and Lewis, 2003) whereas epistemological assumptions are concerned with how knowledge is produced or reproduced (Moss and Moss, 2002). The ontology and epistemology of my research study was very much influenced by the literature review which examined what perceived social reality existed and what research methods had already been applied for its discovery and what their shortfalls were. The descriptive analysis undertaken in the context of a quantitative research method as part of this study relates to my ontological assumptions and captures what there is to know. The epistemological position that my research study adopts is that of a social constructivist which implies that our knowledge of the world and how we understand it is derived from how people construct it between them rather than the nature of the world (Burr, 2003) and that our experiences as well as perceptions are ‘mediated historically, culturally and linguistically’ (Willig, 2008,13). In other words, social constructionists believe that there are more ‘knowledges’ rather than there is ‘one knowledge’. Social reality is also assumed to be an ongoing dynamic process that people produce daily according to their own knowledge and its interpretation.

The research aim was to discover the perceived reality of the individual doctors, who are likely to have their own particular construction of social reality, and which will be co-constructed collaboratively between myself as a researcher and the researched. This process of co-construction is further explained in the following section on reflexivity and interviewing.
3.4 Reflexivity in the Research Process

Reflexivity requires the process of data collection and its analysis to be made explicit. There are two types of reflexivity, epistemological and personal reflexivity. In this section I will discuss epistemological reflexivity. Personal reflexivity which relates to researchers’ own impact on the research process will be discussed in the section 3.12.

Epistemological reflexivity requires the researcher to analyse the research questions. For example, the researcher needs to ask himself/herself whether the way the research question was set aided or limited what could be ‘found’, and should make it explicit how their design of the study contributed towards the construction of the data and the research findings, that is, whether the research study could have been investigated in a different way than to the proposed one and what impact this may have had on our understanding of the phenomenon under investigation. In summary, epistemological reflexivity assists a researcher to reflect on the assumptions they made during the course of the research study, which consequently helps them understand the implications and limitations of the study findings (Willig, 2008; Bryman, 2009). The above issues will be further discussed in section headed 3.12 Personal Reflexivity.

3.5 The Application of Mixed Methods

The use of a quantitative method was considered for this research as it can demonstrate particular patterns and trends in relation to when, where and how many overseas-trained South Asian doctors entered into General Practice. However, the limitations of statistical analysis were also acknowledged as numbers alone cannot reveal the complex lives and subjective experiences of overseas-trained South Asian doctors in the UK.

Kvale (2008) states that different research questions need different methods which means the application of different tools, and that quantitative methods refer to ‘how much of a kind?’ whereas qualitative methods refers to ‘what kind?’. The underlying principle in the
proposed research design was the application of a methodology offering ‘completeness’ and a ‘comprehensive picture’ (Poortinga et al., 2004). Creswell (2009, 14) acknowledges an additional advantage of objectivity, and states:

Recognising that all methods have limitations, researchers felt that biases inherent in any single method could neutralise or cancel the biases of other methods.

The study used a two-stage research design involving sequential mixed methods procedures and Table 1.1 in Chapter 1 outlined the research questions. As the first question is orientated towards measurement, it is more suited to a quantitative method and a descriptive analysis whereas the latter four questions (2-4) are of a subjective nature that relates to the meaning that the individuals ascribe to their experiences, so are therefore more suited for a qualitative research and analysis. In order to capture the diversity of experiences three case study areas were selected that reflected the urban/rural mix and low/medium/high ethnic density.

3.6 Reliability and Validity

Reliability relates to the consistency of a measure of a concept whereas validity attends to the issue of whether a devised indicator really measures the concept in question. An IQ test is an example where the validity of the measurement for the concept of intelligence can be questioned (Bryman, 2009). Although reliability and validity can be analytically distinguished, these concepts are also inter-related in that validity supposes reliability, in other words, a measure is not valid if it is not reliable (Bryman, 2009). This research study uses both quantitative and qualitative methods and concepts of reliability and validity apply to both contexts, though traditionally, they have been more commonly utilised in quantitative research. However, different criteria govern the reliability and validity in quantitative and qualitative methods as both types of enquiry have evolved from different philosophical, methodological and theoretical positions such as positivist and constructivist.
paradigms (Guba and Lincoln, 1989). For this reason, the criteria used to assess the reliability and validity of quantitative research is related to whether similar results for a study can be replicated under similar circumstances such as the study in question. Validity here requires that the methods utilised in generating a set of findings are specified so that they become replicable. This forms an important part of quantitative research and is fully addressed in Chapter 4.

However, in qualitative research, the assessment of quality of research is about the suitability of the design of the research including the accuracy and adequacy of the measurement tools used to measure the intended social phenomenon (Creswell, 2007, 206). The author contends that validity concerns alignment between research design and data gathering and how they allow for a conclusion to be drawn in a confident manner, in other words, how well data interpretation can take place based on the specific procedure utilised. Strategies suggested by Creswell for validity in social research also include external evaluation through debriefing sessions in which questions can be asked about the credibility of the research process. I achieved this by presenting preliminary findings to internal research seminars as well as external poster and paper presentations (see Appendix 6 &7).

3.7 Analysis of GP General Medical Services Database

A secondary data analysis was undertaken which provided an analysis of the GP workforce at a national level, and the findings served as a baseline for the qualitative method. The dataset considered that the most authoritative and reliable source was The General Medical Services (GMS) database which consists of NHS workforce statistics compiled from
around 400 NHS organisations, and on behalf of around 8,200 GP practices in England and Wales\textsuperscript{4} for the period 1992-2009.

The analysis also aided in determining the parameters of the sampling frame. This secondary data analysis of NHS workforce statistics is used to answer the first research question by examining variations between individuals in terms of the social characteristics stated above such as age, sex, geographical locale and ethnicity. In order to determine the sampling frame, cross tabulation was undertaken of country of qualification, SHA and year 2001 for each of the case study areas. The results show that there were 32 South Asian qualifiers in Sheffield, 55 in Manchester and 37 in Barnsley. The next step was to determine the age range so as to ensure that the sample had a sufficient number of doctors in the 50 plus age range. The results showed that there were 25 overseas-trained South Asian GPs in the age range 50-59 in the Barnsley sample, for Manchester, 38 and for Sheffield, 17 GPs which is a sufficient number. The results confirmed the validity of the case study areas. A more detailed discussion of this method is documented in Chapter 4.

3.8 Semi-structured Interviews

Since the primary research aim, addressed by the remaining research questions is to investigate how the overseas-trained South Asian GPs construe their experiences in the above contexts; the use of a self-administered questionnaire was considered to be an inappropriate tool as this would require the research subjects to re-construe their experiences within the framework of the ‘prevailing research paradigm’ (Rojiani, 1994). Interviewing is believed to be one of the main and most powerful tools used to gain an insight into the world of others (Legard et al., 2003). For this reason, a survey conducted by questionnaire was rejected in favour of semi-structured interviews which would sufficiently bind the social phenomena being studied without imposing preconceived

\footnote{http://www.ic.nhs.uk/webfiles/publications/workforce/nhsstaff9909/NHS_Workforce_Census_Data_Quality_Statement.pdf}
structures upon it. During the qualitative data collection phase, a case study approach was applied to explore processes specific to local areas. The focus here was to compare experiences of GPs in three contrasting geographical contexts at a smaller scale but in greater depth. The interviews undertaken were semi-structured and the themes explored were derived from the theoretical concepts identified previously such as community cohesion indicators, social capital and related to demographical information of the participants, migration and settlement experiences, employment in the NHS, links with other professionals and organisations, transnational role and reflections on their personal and professional journeys in UK. The interviews explored, in depth, the patterns emerging from the analysed quantitative dataset and a full list of themes covered as well as an interview guide is attached (see Appendix 1).

3.8.1 Strengths and Limitations of Semi-structured Interviews

Semi-structured interviews have a degree of structure, however, the use of open ended questions allow interviewees’ flexibility to tell their stories spontaneously in their own words (Bowling, 2009) with richness and detail (Oppenheim, 2000) and pursue topics of particular interest to them (Bryman, 2009). Seidman (1991, 69) advocates for in-depth interviewing as this method is ‘primarily designed to facilitate informants to reconstruct their experience and to explore their meaning’. This approach appears eminently suited to eliciting overseas-trained South Asian doctors’ understanding of their own experiences and the meaning they make of their experiences. Semi-structured interviewing presents a space for investigating in great detail the perceptions of participants in relation to their lived professional and personal experiences. Wengraf (2001,6) emphasises the meaning of ‘depth’ stating that:

*To go into something ‘in-depth is to get a sense of how the apparently straight-forward is actually more complicated, of how the ‘surface appearances’ may be quite misleading about ‘depth realities’.*
Other positive aspects include the choice participants have for expressing themselves in their preferred language; in addition any confusion arising from the use of particular words can be instantly dealt with using standardised explanations (Oppenheim, 2000).

Kvale (2008) regards the interviewer as the ‘primary research instrument’ in qualitative research and the ‘interrelationship’ between interviewer and interviewee as significant in relation to obtaining knowledge. Kvale reminds us about the demands that the above places on researchers regarding the quality of their research, and their ability to be empathetic and creative in their approach. A lack of such qualities may jeopardise the research quality. Interviewing elite subjects such as the participants in this study can be a challenging task (Harvey, 2011) and characteristics such as ethnicity, gender, religion, culture of both the researcher and researched can hinder the research process. Interviewers need to build rapport and present themselves in a manner that is acceptable to the elite subjects. This is important not only to obtain high quality responses but also because these participants can act as gatekeepers and restrict additional contact if they do not approve of the interviewee (Harvey, 2011). Lack of rapport between researcher and interviewee, and the problem of interviewer bias can hinder the research process.

3.9 Selection of Case Study Areas

Central to this study was the question of how the contextual factors in different localities impact on the identities of overseas-trained South Asian doctors. A case study based approach was chosen in order to capture comparisons of GP experiences in three contrasting geographical contexts. The case study approach allows the consideration of different patterns of settlement, the overcoming of structural barriers and how the doctors in the study negotiated their own agency in different geographical contexts. The characteristics of the three case study areas are illustrated in the following table:
Table 3.1: Characteristics of Geographical Locales

<table>
<thead>
<tr>
<th>Characteristics of Place</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 A major urban area with high ethnic density.</td>
<td>Manchester</td>
</tr>
<tr>
<td>2 A large urban area with average ethnic density.</td>
<td>Sheffield</td>
</tr>
<tr>
<td>3 A semi-rural area with low ethnic density</td>
<td>Barnsley</td>
</tr>
</tbody>
</table>

The choice of Barnsley, Sheffield and Manchester was motivated by the similarities and the differences in their locations. All three areas have a high density of overseas-trained South Asian doctors. The ethnic density and physical environment of the cities are different. The varied contextual factors allow an analysis of the key factors that can impact social interactions, place attachment and identities. The contextual factors of the case study areas are documented in detail in Chapter 7.

3.10 Sampling Strategy

In the qualitative data investigation, it was important to determine the sample characteristics of the potential interviewees, sampling method, sample size and techniques used. I will discuss each one under sub-headings below.

3.10.1 Overseas-trained South Asian Doctors’ Sample Characteristics

The decision to select the characteristics of this research sample was guided by the criteria requirement of the research questions (Ritchie, 2003) and included overseas-trained South Asian GPs of both sexes, aged over 50 years who had practiced in any one of the case study areas. It was decided to focus on doctors of over 50 years of age as they were more likely to have been in the UK and General Practice for the last two decades. This was partly to do with matching the qualitative sample with that used in the quantitative analysis and partly to do with the anticipation that using this timeframe was likely to capture earlier
and more varied experiences of migration, as well as a longer term perspective on community cohesion. The statistical analysis provided detailed information as to the composition of overseas-trained South Asian doctors in the sampling frame in each of the case study areas. Access to Bangladeshi and Sri Lankan trained doctors was not gained as they were not in the sample frame for the selected settings for the specified period. This means that the use of term ‘South Asian’ only includes overseas-trained doctors of Indian and Pakistani origin in this study. The interviewees were aged 50-76 years and had migrated from India and Pakistan. The detailed demographic characteristics of the interviewees are discussed in section 5.2 of chapter 5.

3.10.2 Sampling Methods

The qualitative research strategy involved undertaking a sample in a strategic manner rather than sampling on a random basis. A purposive and stratified sample was taken based on the findings from the quantitative analysis, meaning that the sample was selected in an intentional and non-random manner to achieve a certain goal. There are a number of approaches available within purposive sampling. The two approaches applied in this research study are criterion and snowballing. The descriptive analysis informed the sampling frame and participants were purposively selected to ensure that they reflected diversity in the context of demography and geographical location i.e. rural/urban as required. A quota sample was envisaged to ensure that an equal number of participants was selected from each case study area. I also employed theoretical sampling in my approach which means that sampling was continued until a saturation point was reached and no new concepts were emerging (Bryman, 2009). This meant that I had a slightly larger sample in Sheffield.
3.10.3 Snowball Sampling Technique and its Limitations

The interviewees were identified by a snowball method that focused on professional networks and searching GP practices in the case study areas, a technique for finding research subjects which entails making initial contact with one or two research subjects who give the name of another subject who in turn gives the name of another and so on (Atkinson and Flint, 2001; Bryman, 2009). The snowballing strategy was used with the anticipation that it was essential to have someone’s trust to initiate contact as these are an elite group of individuals, and likely to be hard-to-reach by other means by nature of their employment status, their ethnicity (Atkinson and Flint, 2001). This method utilised their social networks to provide further potential contacts. The interviewees in my study shared the characteristics listed above and snowballing was considered an effective strategy. To overcome possible ‘selection bias’ associated with snowballing strategy, attempts were made to generate a large sample to include ‘isolates’ (Atkinson and Flint, 2001) and other complimentary strategies were used alongside snowballing to recruit interviewees. For example, information regarding the research project was sent out to GP practices managed by GPs with South Asian names as well as to BAPIO, the CASE partner organisation and other user organisations.

Some doctors declined to be interviewed which may be related to a genuine reason such as a busy schedule. Some may also have had other reasons such as negative experiences within the NHS, researcher’s gender/ethnic/cultural background or institutional link.

3.10.4 Sample Size

There are ongoing debates about how large a qualitative sample should be and a study undertaken by Mason (2010) on 560 PhD studies found that the number of respondents in the studies varied greatly; additionally, a wide range of sample sizes were utilised by the researchers, the most common sample size being between 20-30. A guiding principle for
the sample size in qualitative research is to adhere to the concept of saturation which means the point at which researchers reach a stage in their data collection where little new evidence is being gathered (Mason, 2010). However, authors such as Guest et al. (2006), Charmaz (2006) and Creswell (2007) also agree that saturation does not need a large sample size. In addition, Morse (2008) believes that an interviewer’s skills undoubtedly have an impact on the quality of data collected and Guest et al. (2006) argue that this will consequently aid in achieving saturation earlier rather than later. I used the features of the qualitative software package Nvivo’s features, such as screenshots of coding frameworks and analytical models, to aid in an ‘overt description’ of how saturation was attained. Guest et al. (2006, 78) suggest that a sample as small as 6 interviews may be sufficient in populations where there is likely to be a high level of homogeneity in order to develop ‘meaningful themes and useful interpretations’. Guest et al. (2006) argue that a sample of 12 is sufficient if the goal of research relates to describing a perception, behaviour or belief that is shared among a relatively homogenous group. However, a stratified sample (quota) is required if the researcher intends to determine the difference within groups in relation to a specified dimension and the researcher may have a purposely selected sample of 12 participant within each group of interest. The interviewees in my research study can be described as relatively homogenous in many areas such as age when they entered into General Practice, practice conditions and gender. In the light of the above considerations and available resources, the sample was restricted to a total of 27 in-depth interviews with GPs and based on a quota from each of the three contrasting geographical contexts, profiles of which are discussed above. A quota sample consisting of 8 participants was purposely selected in each of the case study areas, however, sample size in Sheffield increased to 11 for reasons explained earlier.
3.11 Qualitative Data Collection Processes

Guidance notes for in-depth interviews were developed through informal discussions with GPs from the targeted research population (Appendix 1). Knowledge was also incorporated into the question guide from a thorough literature review and existing biographical literature. Interviewees were contacted by telephone and interviews were arranged either at their home or at their practices. Written consent was taken for quotations to be used in the thesis. The interviews were digitally recorded. The topic guide was used during the interviews incorporated techniques advocated by Lazarsfeld (1972) in that questions should be fitted to the experience of the researched and that they should be fixed in meaning rather than wording. The art of asking the right questions triggered interviewees’ memory accordingly and they felt at ease in remembering a sequence of events. Consultations also took place with the user organization, the British Association of Physicians of Indian Origin (BAPIO). Following the approval of the ethical procedures, pre-piloting was undertaken followed by a pilot study to test and evaluate the question guide regarding the wording, clarity of the proposed questions, ease of understanding, time needed to complete the interviews, the order of the questions and to ensure that the questions were focused on the core goals of the research. An interesting and important aspect was uncovered during this stage: the significance of first language. The interviewees, somewhat hesitant at first to express themselves in their first language, then spontaneously switched into it and were articulating in poetry and prose in the South Asian languages. The interviewees’ responses echoed what Burr (2003) argues, that is, that language is about more than simply expressing ourselves. Burr (2003, 4) adds:

*It is through the daily interactions between people in the course of social life that our versions of knowledge become fabricated. Therefore social interaction of all kinds and particularly language is of great interest to social constructionists.*
Burr refers to the work of Whorf (1941) who believed that it is a person’s language that determines the way the individual perceives the world. Burr adds that:

.....this means that the way a person thinks, the very categories and concepts that provide a framework of meaning for them are provided by the language that they use.

As the interviewees appeared relaxed and responded positively, this confirmed that the content and art of questioning were working effectively. Some other minor changes were made regarding the wording and the sequence of the questions. Based on this observation, the interviewees were given a choice to express themselves in the languages that they felt most at ease hence reducing the need for multiple interviews.

3.12 Personal Reflexivity

Personal reflexivity is related to researcher’s contribution in the research process. It is defined as follows by Willig (2008, 10):

Personal reflexivity involves reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research.

Bolognani (2007) refers to literature which places emphasis on ‘interview matching’ in the context of ethnic or linguistic similarity. I believe that the experiences of being a migrant, Asian, a woman, having had several professional roles in the UK, and of being ‘othered’ while living in Britain served me well in enriching the quality of my research (Oguntokun, 1998) and that my attributes enabled the participants to disclose information which may be regarded as of a highly sensitive nature (Song and Parker, 1995). Moss and Moss (2002) takes the above a step further and questions the type of epistemology applied in research such as Marxist, anti-racist or feminist epistemology. Moss argues how feminist scholars have had to fight not only that ‘knowledge’ is inclusive of ‘women’s voices’ but also how
the data might be affected by the gender of the researchers and the researched. The principles of anti-racist research are explained by Dei and Johal (2005, 257) as follows:

*Anti-racist research does not just deal with ‘social facts’, it is also about how people interpret those facts, how the researcher interprets those interpretations, contextualizes them, and assists the subject in developing theoretical understandings of their lived experiences.*

The epistemology of my research study was very much influenced by the above mentioned elements and the application of a mixed methods approach was considered to provide a comprehensive picture.

A cornerstone of the process in interpretive research is the researcher’s own reflexivity (Paulus et al., 2008) as a researcher is always implicated in the research process of all qualitative methodologies in one way or another (Willig, 2008). My own background is in social work and having worked in the field for three decades I believe I am well experienced in interviewing skills. I migrated from Kashmir (Pakistan) to the UK after having completed my secondary and further education in Pakistan, where the education medium was Urdu. The combination of different fields of knowledge that I have gained over the years, my own migration experience as well as being a daughter of a migrant (who had come to the UK to work in the steel industry (due to the post-war labour shortage), as well as and being the parent of a daughter who is herself a doctor helped me enormously in understanding the complexity of these issues, and I believe I was well placed for this particular project. I have had a lot of personal and professional experience of interacting with this group of people whose contribution I personally value. As a migrant and female, I have had my own struggles in relation to structural inequalities including racism. I am aware that my own interests and experiences are helpful in the research process, however, through a transparent reflexive process, I need to critically examine the evidence that is grounded in the accounts of the interviewees and recognise my own biases.
I believe that my research is organic in various ways and that I played a central role in constructing the social reality of the research subjects. I designed the research strategy, developed the topic guide, and conducted the face to face interviews incorporating my expertise in the cultural and linguistic aspects. I believe that my own characteristics and networks helped tremendously in negotiating access to the respondents as these characteristics conveyed *an implicit message about credibility and openness* (Ritchie et al. 2003, 65).

I allowed the interviewees to articulate their feelings/responses in the languages that they felt most comfortable. From my own experience, I was well aware that discussions around sensitive issues can be more usefully articulated by individuals in their first languages as it is a fact that, in emotional situations, we, as humans, always have a tendency to regress to our first language. This assertion of mine was proven during the interviews where interviewees often articulated their feelings by means of referring and reciting Urdu/Hindi poetry which I was able to fully comprehend because of my own secondary education in Pakistan. The pre-occupation of the doctors from the Indian subcontinent with using poetry as an expressive mode was related to the fact that they all had been exposed to a similar educational style, prior to partition in 1947 and possibly after this period. Communicating to the masses through the medium of poetic expression was a norm, and also a language of the elite.

The above knowledge and skills enabled me to build a rapport with this elite group of people and elicit information required with relative ease. Kvale (2008) discusses the significance of the first minutes of an interview and states that they are crucial in relation to the quality of the interview as a whole, as the participants will want to have some knowledge of the interviewer before opening up and allowing their inner world to be exposed.
In order to gently ease into the research topic, I began by explaining the aims and objectives of the research and shared my own history as a migrant in this country (Rubin and Rubin, 2011). This was done with a view to breaking down the barriers between us creating a safe environment and a ‘climate of mutual disclosure’ in which the participants were able to share their deepest thoughts, feelings and emotions. The exposure of my inner feelings and experiences ‘legitimised’ the interviewee’s account by the articulation of our ‘reciprocal revelations’ and enabled the doctors to continue sharing their own story (Holstein and Gubrium, 2010). I believe that for the discovery of ‘truth’ that I was after in this research, self disclosures were important at appropriate times, for example, the interviewee seemed to open up more when I shared my own experiences of racism. I also felt that my communication was further facilitated by sharing personal information about being a parent of a doctor who was born and educated in the UK; the interviewees appeared more ‘approving’ of me.

In spite of there being similarities, I believe there was still constant fluctuation of my status in terms of being an insider and outsider. The Interviewees regarded me as an insider in relation to religious, cultural and linguistic background whereas at other times I was informed that I was not a medic and that I would not understand the issues. Welch et al. (2002, 611) discuss challenges that are compounded in elite interviewing by ‘differences in professional values, seniority, gender, culture and language skills’ all of which I encountered. I was very aware of power dynamics as there were issues related to the interviewees being an older generation, as well as professional, elite, cultural reasons that emerged, alongside gender, class, and religious differences, all of which I had to navigate in a sensitive manner to balance the power of elite interviewees.

As I was interested in the meaning that the doctors ascribed to their experiences throughout the interview, I always asked individuals for clarification rather than relying on ‘taken-for-granted assumptions’ (Rubin and Rubin, 2011). This was achieved by gentle probing into
the remarks the interviewee’s made from time to time when I repeated their words and asked them to elaborate on what they had said. The interviewees were asked similar questions, however, additional questions were asked based on the interviewees’ responses.

3.13 Quantitative Data Analysis

In the first phase of the analysis, an exploratory analysis was undertaken to analyse the data which consisted of a descriptive analysis of GPs, their identities, and employment pattern in the UK for the period 1992-2009. The dataset for an earlier period than 1992 was not available. The purpose of this analysis was to examine the proportion of overseas-trained South Asian doctors in the total GP workforce, their demographics, where they were employed and how this has changed over time. The key variables explored were country of qualification, geographical location, period of working as a General Practitioner, and gender. A variable is an aspect which differs among cases, for example age, sex etc. (Ragin and Amoroso, 2010).

3.14 Qualitative Data Analysis

Perakyla (2004) argues that transcripts are regarded as ‘raw material’ in qualitative research, therefore the quality of transcribed material has important implications for the purpose of analysis. The interviews were transcribed by myself and a research assistant with medical knowledge. Since validity and reliability are important issues in social science, I took particular care with how the transcripts were produced. Vygotskij (1987, 236) also point out the significance of transcribing full interviews and states, ‘Every word that people use in telling their stories is a microcosm of their consciousness’. I transcribed the interview scripts using interviewees’ verbatim responses in English and Urdu simultaneously as interviewees often switched between English and their first language. I did this with great care and without losing the meaning in the original language. The material that was not relevant was kept in reserve.
Halai (2007) contends that complexity of the process in the conversion of field texts to research texts is further enhanced when the data is bilingual or multilingual which was the case in this study. I was conscious of the cultural decoding that translation requires (Torop, 2002). Halai (2007, 345) describes this process as boundary crossing between two cultures that involves conversion of ideas from one language for one social group to another language for another social group. Involving of translators raises methodological and epistemological challenges in relation to how knowledge is produced because individuals’ location within the social world influences the way in which they see it (Temple and Young, 2004). Being a qualified linguist myself in Urdu proved useful. My instruction to the transcriber was to transcribe everything verbatim in English and Urdu. There were ongoing discussions between myself and the transcriber concerning cultural decoding. Rather than ‘exact equivalence’, I aimed for ‘inexact equivalence’ as the former is impossible, ensuring that essential meaning is conveyed (Crystal, 1994, 346). On occasions where it was difficult to convey the right nuance of meaning and being conscious that some meaning is lost in translation (Halai, 2007), I provided the original text in Roman Urdu (Khan and Khan, 2002). Listening attentively to each word and paying attention to the emotional tone attached to the words helped me to understand the meaning of what was being narrated for the purpose of analysis (Rubin and Rubin, 2011). The analysis was undertaken by way of thematic analysis. Braun and Clarke (2006, 82) define it as follows:

A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set.

Thematic analysis refers to a process whereby, having familiarised myself with the data and (Ritchie and Spencer, 1994) I revisited the research objectives and thoroughly read all the transcripts, then I listed key ideas, recurring themes and the issues that transpired to be important to the respondents themselves during the interviews (Burgess and Bryman, 1994). The strategy I employed in the data analysis was an inductive analysis and I looked
for patterns and categories emerging from the data (Patton, 1990). The themes developed included reasons for migration, experiences in the NHS, entrepreneurship, identity, experiences of racism and coping strategies, doctor-patient relationship and transnationalism. Each theme included subcategories, for example, the subcategories for migration included reasons for migration, processes for migration and networks. Some of the subcategories that did not produce any data were later collapsed. The analysis was undertaken using the computer software Nvivo, version 9 to aid transparency, validity and reliability (Gibbs, 2002).

Corbin and Strauss (2008, 13) emphasise the self-awareness of the researcher, who is, in other words, also an interpreter and an essential part of the research process and its findings. They further add that keeping a journal and writing frequent memos concerning reactions and feelings during the data collection and analysis process helps the researcher recognise their potential influence on the research and vice versa. Nvivo offers the facility of structured recording of memos to help the researcher manage the above issues. I used memos for the storage of my reflective journal that documented my journey from initial stage to conclusions. I also stored other relevant documents such as my research proposal. I found it useful to record key issues from each transcript in one combined document that I could later look at to develop common themes. I also took note of silences in the data and kept memos for further exploration.

3.15 Ethical and Methodological Considerations

The broad ethical issues in any research relate to objectivity, the research being worthwhile, the appropriateness of the research tools and techniques utilized, and the application of sensitivity to the respondents. These were addressed throughout the thesis. For the qualitative research where in-depth, semi or unstructured interviews are planned, the likelihood of unexpected issues arising is increased, which means that ethical considerations are even more significant in qualitative research studies (Ritchie, 2003).
The major ethical issue in any qualitative research is related to the treatment of the participants (Blaikie, 2000), which is also echoed by Denscombe (2002). The main areas of concern that were addressed in this study related to voluntary participation, informed consent, potential risk of harm, confidentiality, anonymity and securing of GP database data (see Appendix 3). Formal ethical approval was obtained from the University of Manchester’s Committee on the Ethics of Research on Human Beings which was formulated in 2010.

In relation to the methodological considerations, some limitations should be taken into account when interpreting the results of this study. There were some inaccuracies in the database in relation to the country of qualification, for example, 315 individuals had an unidentified country of qualification. The use of proxy measure, that is, country of qualification and country of birth used for determining ethnicity, may also not capture the full picture (Gill et al., 2003). In addition findings from in-depth interviews cannot be generalised as the aim is not to seek representative views, but rather ‘to generate data which gives an authentic insight into people’s experiences’ (Silverman, 2011) and to generalise a theory rather than people (Bryman, 2009). The findings are contextually unique, therefore methodology has its limitations. The qualitative analysis is based on Indian and Pakistani doctors’ interviews only and females were under-represented in the sample. Social desirability where individuals’ responses may relate to what is socially acceptable or politically correct, rather than an answer that is reflective of their true attitudes (Knoll, 2013), as well as interviewees’ viewpoints whereby their ‘own retrospective analysis on past events, research context and the fact that research only focuses on the interviewees can be seen to add to the limitation to the study.
3.16 Summary and Conclusion

This chapter specified the methodological framework for this study which included clarification of methods and methodology. It provided a detailed discussion of the research design and its ability to answer the research questions together with its limitations, and the rationale for the selection of case study areas. The following chapter will describe the results of the descriptive analysis.
Chapter 4: Analysis of GP Workforce in England and Wales, 1992-2009

4.1 Introduction

This chapter relates to research questions 1a and 1b which concern exploration of issues related to structural integration of overseas-trained South Asian doctors in the NHS. The key questions concerned with investigation of what proportions of overseas-trained South Asian doctors existed in the UK GP workforce over the period of 1992-2009 and what their demographics, key locations of employment were and how this pattern changed over this period. Previous studies show a discrepancy regarding the scale of migration of overseas-trained South Asian doctors and provide different statistics and are also somewhat out of date. It was considered important to look into the macro-level structures and to investigate whether structural inequalities exist for overseas-trained South Asian doctors. The use of a quantitative method was considered appropriate as it can demonstrate particular patterns and trends in relation to when, where and how many overseas-trained South Asian doctors entered into general practice. In answering the above research questions, I undertook a secondary data analysis of GP Workforce Database for the period 1992-2009 and I will discuss the results in this chapter. First, I will discuss data and methods applied.

4.2 Data and Methods

The data for this analysis comes from the administrative data set ‘The General Medical Services’ for the period 1992-2009. It was obtained from The NHS Information Centre for health and social care which annually collates data submitted by NHS Trusts and PCTs on behalf of GP practices in England and Wales. The variables in the database include country of primary medical qualification, age band, year, GP sex, GP type, full time equivalent (FTE) working hours, practice code, PCT name, PCT code and Strategic Health Authority, (SHA).
There were 134 GP qualification countries represented in the dataset which were grouped as follows: United Kingdom (UK), European Economic Area (EEA), South Asia, Developing Countries and Developed Countries, in order to compare different patterns that may exist within and across different groups. Table 4.1 provides a description of the recoding undertaken. As there is no information available on ethnicity or country of birth, it cannot be assumed that a GP, who for example qualified from a South Asian country necessarily originated from that country, though it is likely that a vast majority did so. For this reason, the doctors will be referred to as qualifiers from that country throughout the chapter. The following table shows the coding categories employed in the analysis.

<table>
<thead>
<tr>
<th>New Variable</th>
<th>Old Variable</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>Country of qualification: only includes those qualified in England &amp; Wales</td>
<td>Includes England &amp; Wales only</td>
</tr>
<tr>
<td>South Asian (SA)</td>
<td>Country of qualification: India, Pakistan, Bangladesh and Sri Lanka</td>
<td>One variable was created for all the South Asian countries specified in the list</td>
</tr>
<tr>
<td>European Economic Area (EEA)</td>
<td>Country of qualification-Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, Iceland, Irish Republic, Italy, Latvia, Lithuania, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain</td>
<td>One variable was created for all the countries listed</td>
</tr>
<tr>
<td>Developed countries</td>
<td>Australia, Canada, New Zealand, USA, Switzerland</td>
<td>Economically affluent countries outside the EEA</td>
</tr>
<tr>
<td>Developing Countries</td>
<td>The remaining 134 countries including countries: Egypt, Syria, Turkey, Sudan, Somalia, Libya, Kenya, Nigeria etc</td>
<td>Less economically affluent countries outside the EEA</td>
</tr>
</tbody>
</table>

4.3 Results of Descriptive Analysis

4.3.1 A General Description of the GP Workforce in the UK, 1992-2009

An initial frequency test was conducted for each variable to find out if there were any missing values and 315 doctors out of the 69,005 whose country of qualification was
unknown were excluded from the country of qualification analysis. Further analysis showed that many of these 315 doctors came into General Practice in the earlier years; however, 108 of them started practising in 2009. The missing data may be a reflection of inaccuracies in the updating of the data system. Following this, I looked at the total number of GPs and the composition of GP groups by country of qualification within the workforce across the time period 1992-2009 and also examined the development of particular emerging patterns.

Figure 4.1 shows the composition of the GP workforce in the UK which in 1992 consisted of 79% UK-trained and 21% overseas-trained. Figure 4.2 shows that in 1992, 21% of GPs in England and Wales qualified overseas. Of these, 73% qualified in South Asia. In 2009, the proportion of overseas-trained South Asian GPs had fallen to 51% of overseas-trained GPs (Figure 4.3); while the proportion of overseas-trained GPs from developed countries more than doubled to 27% of overseas-trained GPs. EEA-trained and non-EEA developed-trained remained quite similar to the 1992 figures, at 18% and 1% of overseas-qualified GPs respectively.

Figure 4.3 shows that the proportion of overseas-trained South Asian GPs dropped from 73% in 1992 to 54% in 2009; however, they remain the largest group of overseas-trained GPs. In 1992, EEA-trained GPs were the second largest group whereas in 2009, the second place was taken by the developing countries who now make up 27% of all overseas-trained in comparison with 11% in 1992. The percentage of EEA-trained GPs showed an increase of 3 percentage points. There was no difference to the proportion of those trained in developed countries for the period 1992-2009.
Figure 4.1: Distribution of all GPs by Country of Qualification in the UK in 1992

Figure 4.2: Distribution of all Overseas GP groups in 1992

Figure 4.3: Distribution of all Overseas GP groups in 2009

Source for Figures 4.1-4.3: The Health and Social Care Information Centre
Table 4.2 shows the results of frequency and percentage for each group over the period 1992-2009. It shows the total number and percentage of GPs 1992-2009 between in the right hand side column. There were 30,000 GPs practising in the UK in 1992, of which UK-trained GPs represented 79.5%, of the total GP workforce, meaning the remaining 20.5% was made up of overseas-trained GPs.

The proportion of UK-trained GPs remained steady between 1992 and 2001, showing a marginal increase from 79.5% to 81.8%. Between 2001 and 2009, the figure starts to decline and reaches its lowest level in 2009 at 76.7%. EEA-trained GPs made up 3.1% of the total workforce in 1992 and their number gradually increasing over the years reaching its peak in 2006 at 4.7%. The number of EEA-trained GPs fell slightly from 4.7% in 2006 to 4.2% in 2009. South Asian-trained GPs represented 14.9% in 1992; with the figure gradually decreasing reaching its lowest level in 2003 at 10.9%. One reason for this drop in numbers is to do with the fact that out of the earlier cohort of South Asian-trained GPs, the majority were older than their UK counterparts when they entered General Practice (Smith, 1980; Taylor and Esmail, 1999) and were now retiring. The retirement of overseas-trained South Asian GPs was an event so significant that it caught the attention of media. The BBC News Channel\(^5\) reported (26 November, 2003) in an article *How Asian Doctors Saved the NHS,*

> Today, as the 1960s generation collectively approach retirement, the NHS is facing a crisis once again - and this time the health service may not be so lucky.

The article concludes with the comment ‘And, once again, the NHS is also looking abroad for help.’ Other contributory factors to this low level of workforce participation may include low recruitment activity from South Asian countries during this period, due to restrictions placed on migration, relatively slow growth in NHS funding and new

\(^5\) *How Asian Doctors Saved the NHS, BBC News, 26 November, 2003*
http://news.bbc.co.uk/1/hi/health/3239540.stm
recruitment from EEA and developing countries. However, between 2005 and 2009, and in contrast to the above, the number of South Asian-trained GPs increased sharply. This increase appeared to coincide with a sharp increase in the total workforce during this period which suggests that the expansion in the NHS workforce, along with funding issues, once again required the NHS to actively recruit doctors from South Asia. However, in addition to this speculation, there appear to be other reasons as highlighted in the article Doctor Shortage Sees New Recruitment Drive in India (BBC News, 1 June 2010). This article reported that the British Association of Physicians of Indian Origin (BAPIO) had approached with a view to help recruit several hundred junior doctors from India. The article provides a useful summary of reasons for the new recruitment drive which included tighter immigration rules, and new European regulations limiting the working hours of doctors. The article refers to the comments made by Professor Derek Gallen, a Postgraduate Dean of Medical Training for Wales:

*We pulled the plug on overseas recruitment far too quickly. [We didn't] realise what the implications of that action would be two, three or four years down the line, particularly with the European Working Time Directive [and the] increased feminisation of the workforce. These are things that have made staffing rotas very difficult.*

The figure for developing countries-trained GPs showed a gradual increase from 2.3% in 1992 to 3.5% in 2003, although, the number sharply increased between 2004 and 2009 from 4% to 6.2%. This group showed the largest proportional growth of all groups from 703 in 1992 to 2652 in 2009. The figure for the developed countries-trained GPs was 0.2%

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6 Doctor Shortage Sees New Recruitment Drive in India

Michael Buchanan BBC News, Radio 4's The World At One, 1 June 2010

http://www.bbc.co.uk/news/10202803
in 1992 and has remained steady over the years with little fluctuations showing an overall 0.1 percentage points difference between 1992 and 2009.

The overall GP workforce expanded from 30,000 to 42,434 in 17 years; however, the results show that this increase was mainly made up of overseas-qualified general GPs. There was a 41% growth in the total number of GPs from 1992-2009, however, the growth in UK-trained GPs was 36%, for EEA-trained, 92%, for South Asian-trained, 20%, for developed countries-trained 90% and for developing countries-trained 276%; in other words, their number increased from 702 in 1992 to 2652 in 2009.7 The trends for overseas-trained doctors are illustrated in Figure 4.4.

Table 4.2: Number and Proportions of Five Groups of GPs Between 1992-2009

<table>
<thead>
<tr>
<th>Year</th>
<th>UK</th>
<th>EEA</th>
<th>South Asian</th>
<th>Developing</th>
<th>Developed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>1992</td>
<td>23853</td>
<td>79.5</td>
<td>919</td>
<td>3.1</td>
<td>4456</td>
<td>14.9</td>
</tr>
<tr>
<td>1993</td>
<td>24132</td>
<td>79.6</td>
<td>915</td>
<td>3</td>
<td>4447</td>
<td>14.7</td>
</tr>
<tr>
<td>1994</td>
<td>24374</td>
<td>79.7</td>
<td>925</td>
<td>3</td>
<td>4451</td>
<td>14.6</td>
</tr>
<tr>
<td>1995</td>
<td>24505</td>
<td>79.8</td>
<td>946</td>
<td>3.1</td>
<td>4375</td>
<td>14.2</td>
</tr>
<tr>
<td>1996</td>
<td>24507</td>
<td>79.9</td>
<td>966</td>
<td>3.2</td>
<td>4375</td>
<td>14</td>
</tr>
<tr>
<td>1997</td>
<td>24887</td>
<td>79.6</td>
<td>1049</td>
<td>3.4</td>
<td>4341</td>
<td>13.9</td>
</tr>
<tr>
<td>1998</td>
<td>25214</td>
<td>79.8</td>
<td>1062</td>
<td>3.4</td>
<td>4215</td>
<td>13.3</td>
</tr>
<tr>
<td>1999</td>
<td>26357</td>
<td>80.2</td>
<td>1174</td>
<td>3.6</td>
<td>4158</td>
<td>12.6</td>
</tr>
<tr>
<td>2000</td>
<td>26791</td>
<td>80.4</td>
<td>1252</td>
<td>3.8</td>
<td>4039</td>
<td>12.1</td>
</tr>
<tr>
<td>2001</td>
<td>27656</td>
<td>81.8</td>
<td>1297</td>
<td>3.8</td>
<td>3750</td>
<td>11.1</td>
</tr>
<tr>
<td>2002</td>
<td>27919</td>
<td>81.4</td>
<td>1415</td>
<td>4.1</td>
<td>3758</td>
<td>11</td>
</tr>
<tr>
<td>2003</td>
<td>28804</td>
<td>81</td>
<td>1505</td>
<td>4.2</td>
<td>3890</td>
<td>10.9</td>
</tr>
<tr>
<td>2004</td>
<td>27934</td>
<td>80.1</td>
<td>1572</td>
<td>4.5</td>
<td>3839</td>
<td>11</td>
</tr>
<tr>
<td>2005</td>
<td>28526</td>
<td>79.4</td>
<td>1666</td>
<td>4.6</td>
<td>4055</td>
<td>11.3</td>
</tr>
<tr>
<td>2006</td>
<td>29785</td>
<td>78.2</td>
<td>1772</td>
<td>4.7</td>
<td>4691</td>
<td>12.3</td>
</tr>
<tr>
<td>2007</td>
<td>29737</td>
<td>77.1</td>
<td>1724</td>
<td>4.5</td>
<td>4750</td>
<td>12.3</td>
</tr>
<tr>
<td>2008</td>
<td>31059</td>
<td>76.7</td>
<td>1695</td>
<td>4.2</td>
<td>5083</td>
<td>12.6</td>
</tr>
<tr>
<td>2009</td>
<td>32539</td>
<td>79.5</td>
<td>1769</td>
<td>3.8</td>
<td>5351</td>
<td>12.7</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre

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7 This figure was calculated using the following formulae
New figure-old figure / old figure x100=the difference %
4.3.2 Trends Among New Entrants Across all Groups

In this section, I will explore the trends occurring among the five groups of GPs between 1992-2009. The analysis described so far only shows the distribution of GPs by year and country of qualification, and is not broken down by date of arrival. A new variable ‘new entrants’ was created to identify when individual doctors first appeared in the dataset with a view to seeing emerging entry patterns. Tables 4.3 and 4.4 show the percentage of GPs in the UK by country of qualification during four time periods, 1992 and earlier, 1993-1998, 1999-2004, and 2005-2009. The first column in Tables 4.3 and 4.4 shows results from 1992 and earlier as 1992 is the first year for which these data are available.

Table 4.3 shows the composition of GPs who qualified in the UK and overseas between 1992 and 2009 in a five yearly period. For the period 1993-1998, the proportions increased for all the groups after 1992 except for South Asian-trained GPs. While there was only a
small increase in the proportion of UK-trained GPs, there was a large increase in the proportion of developing countries-trained GPs. In 1992, the South Asian-trained GPs’ proportion dropped sharply from 14.8% to 5.8%. After this drop, the proportions of South Asian-trained GPs increased quite significantly over the next decade from 5.8% to 19.5%, similarly, the proportions of the developing countries-trained GPs rose from 2.3% to 13.1%, whereas the proportions of UK-trained GPs continued to decline reaching its lowest level between 2005-2009 at 62% in comparison with 79.5% in 1992.

The actual number of South Asian-trained GPs increased from 717 in 1993-1998 to 2517 in the period 2005-2009 showing an overall increase of 251%. In other words, in the period 1993-1998, one in 20 GPs newly entering into General Practice was an overseas-trained South Asian GP, whereas ten years later this ratio was one in five. Smith (1980) found that the overseas-trained doctors in General Practice accounted for one-fifth of GPs from 1950 onwards, however, the results of this study show that one in five new GPs was a South Asian-trained GP by 2009.

**Table 4.3: Percentage of New Entrants in Five Yearly Periods**

<table>
<thead>
<tr>
<th>Period</th>
<th>All GP Groups</th>
<th>UK</th>
<th>EEA</th>
<th>South Asian</th>
<th>Developing</th>
<th>Developed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992 &amp; Earlier</td>
<td></td>
<td>23834</td>
<td>919</td>
<td>4442</td>
<td>701</td>
<td>70</td>
<td>29966</td>
</tr>
<tr>
<td></td>
<td></td>
<td>79.5%</td>
<td>3.1%</td>
<td>14.8%</td>
<td>2.3%</td>
<td>.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td>1993-1998</td>
<td></td>
<td>9960</td>
<td>934</td>
<td>717</td>
<td>744</td>
<td>75</td>
<td>12430</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80.1%</td>
<td>7.5%</td>
<td>5.8%</td>
<td>6.0%</td>
<td>.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td>1999-2004</td>
<td></td>
<td>9757</td>
<td>1142</td>
<td>1525</td>
<td>1176</td>
<td>85</td>
<td>13685</td>
</tr>
<tr>
<td></td>
<td></td>
<td>71.3%</td>
<td>8.3%</td>
<td>11.1%</td>
<td>8.6%</td>
<td>.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td>2005-2009</td>
<td></td>
<td>8007</td>
<td>646</td>
<td>2517</td>
<td>1692</td>
<td>62</td>
<td>12924</td>
</tr>
<tr>
<td></td>
<td></td>
<td>62.0%</td>
<td>5.0%</td>
<td>19.5%</td>
<td>13.1%</td>
<td>.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>51558</td>
<td>3641</td>
<td>9201</td>
<td>4313</td>
<td>292</td>
<td>69005</td>
</tr>
<tr>
<td></td>
<td></td>
<td>74.7%</td>
<td>5.3%</td>
<td>13.3%</td>
<td>6.3%</td>
<td>.4%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre

In summary, since 1992, there has been a steady increase in the share of doctors entering the General Practice register for the first time who have qualified in poorer countries
(South Asia and the developing world) as can be seen in Figure 4.5. The analysis was carried out from 1993 onwards as the figure for 1992 contains all the GPs up until 1992. The results suggest that the NHS, as it has expanded since the late 1990s, has relied increasingly on recruiting new GPs from the developing world.

**Figure 4.5: Percentages of New Entrants in Five Yearly Periods 1993-2009**

<table>
<thead>
<tr>
<th>Period</th>
<th>UK</th>
<th>SA</th>
<th>EEA</th>
<th>Developing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993-1998</td>
<td>80</td>
<td>6</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>1999-2004</td>
<td>71</td>
<td>11</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>2005-2009</td>
<td>62</td>
<td>19</td>
<td>5</td>
<td>13</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre

Table 4.4 shows the column proportions of all five groups between 1992-2009. The results for the year 1992 show the proportions of GPs in all groups who were already in the population. It is striking to see that such a high proportion of South Asian-trained GPs were working in the NHS before 1993. Indeed, of all South Asian-trained GPs, a higher proportion (48%) was practising in or before 1992 than were practising among all other overseas-trained GPs and with a slightly higher proportion than the UK-trained GPs (46%). This evidence supports claims such as this report from BBC News:
For 40 years doctors from South Asia have propped up and provided the backbone to the NHS. They arrived fresh from their medical schools, full of hopes and ambitions.

The results show that other overseas-trained GPs are gradually entering into the workforce, but at a much later stage whereas 48% of the total of South Asian-trained GPs started practising much earlier. This means that a higher proportion of South Asian-trained GPs have been practising for longer than other overseas-trained GPs and in particular, a much higher proportion than among GPs trained in developing countries. The results for more recent years show an increase in the proportions of all overseas-trained doctors, in particular for the South Asian-trained group, confirming what the BBC News report described earlier stated that is, more active recruitment was desperately needed to once again save the NHS after the retirement of a high number of overseas-trained South Asian doctors.

Table 4.4: Percentages of GPs by Period of Entry for Each GP Group

<table>
<thead>
<tr>
<th>Period</th>
<th>UK</th>
<th>EEA</th>
<th>South Asian</th>
<th>Developing</th>
<th>Developed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992 &amp; Earlier</td>
<td>23834</td>
<td>919</td>
<td>4442</td>
<td>701</td>
<td>70</td>
<td>29966</td>
</tr>
<tr>
<td></td>
<td>46.2%</td>
<td>25.2%</td>
<td>48.3%</td>
<td>16.3%</td>
<td>24.0%</td>
<td>43.4%</td>
</tr>
<tr>
<td>1993-1998</td>
<td>9960</td>
<td>934</td>
<td>717</td>
<td>744</td>
<td>75</td>
<td>12430</td>
</tr>
<tr>
<td></td>
<td>19.3%</td>
<td>25.7%</td>
<td>7.8%</td>
<td>17.3%</td>
<td>25.7%</td>
<td>18.0%</td>
</tr>
<tr>
<td>1999-2004</td>
<td>9757</td>
<td>1142</td>
<td>1525</td>
<td>1176</td>
<td>85</td>
<td>13685</td>
</tr>
<tr>
<td></td>
<td>18.9%</td>
<td>31.4%</td>
<td>16.6%</td>
<td>27.3%</td>
<td>29.1%</td>
<td>19.8%</td>
</tr>
<tr>
<td>2005-2009</td>
<td>8007</td>
<td>646</td>
<td>2517</td>
<td>1692</td>
<td>62</td>
<td>12924</td>
</tr>
<tr>
<td></td>
<td>15.5%</td>
<td>17.7%</td>
<td>27.4%</td>
<td>39.2%</td>
<td>21.2%</td>
<td>18.7%</td>
</tr>
<tr>
<td>Total</td>
<td>51558</td>
<td>3641</td>
<td>9201</td>
<td>4313</td>
<td>292</td>
<td>69005</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre

An analysis for the period 2000-2009 was undertaken to examine the trends of all groups of GPs. Figure 4.6 shows that the pattern of new entrants from South Asian qualifiers changed each year with a steep increase while the proportions of EEA-trained GPs
declined sharply reducing to only 3% in 2009, from 11% in 1992. The proportion of the developing countries-trained GPs can also be seen to have increased in each year.

**Figure 4.6: Trends in New Entrants Among the Five GP Groups, 2000-2009**

![Bar chart showing trends in new entrants among the five GP groups, 2000-2009.](image)

Source: The Health and Social Care Information Centre n=69005

### 4.3.3 Trends Among the South Asian Group

In this section, I examine trends among South Asian qualifiers in order to explore the dynamics operating within this group. The existing research literature treats South Asian doctors as a homogenous group. Snape (2005) argues that statistics used to describe experiences in the context of a ‘blanket term’ such as South Asian masks the significant discrepancies that occur within groups of different racial and cultural backgrounds. Katbamna et al. (1998) also refers to the diversity of South Asian people which arise as a result of differential migration histories, settlement patterns, and linguistic, cultural and
religious traditions. For the research objectives of my study, it is important to investigate the trends occurring within the group of South Asian-trained GPs as this knowledge is relevant in determining the sampling strategy.

Table 4.5 provides a breakdown of new entrants from the individual countries within South Asia i.e. India, Pakistan, Bangladesh and Sri Lanka and shows the total percentages of each group within the GP workforce that existed for the period 1992-2009. In 1992, South Asian-trained GPs made up 15% of the total GP workforce, of which 82% were trained in India, 6% in Pakistan, 5% in Bangladesh and 7% in Sri Lanka. The overall composition changed in the following ten years: the proportion of Indian-trained GPs fell from 82% to 72%, Pakistani-trained GPs rose from 6% to 22%, Bangladeshi-trained GPs dropped from 5% to 2% and Sri Lankan-trained GPs dropped from 7% to 4%. The number of Pakistani-trained GPs rose from 263 in 1992 to 1191 in the period 2005-2009, showing the largest increase of all South Asian-trained GPs.

Table 4.5: Trends Among South Asian-trained GPs Between 1992-2009

<table>
<thead>
<tr>
<th>Period</th>
<th>South Asian Qualifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>India</td>
</tr>
<tr>
<td>1992 &amp; Earlier</td>
<td>3650</td>
</tr>
<tr>
<td></td>
<td>82.2%</td>
</tr>
<tr>
<td></td>
<td>73.4%</td>
</tr>
<tr>
<td>1999-2004</td>
<td>1121</td>
</tr>
<tr>
<td></td>
<td>73.5%</td>
</tr>
<tr>
<td>2005-2009</td>
<td>1802</td>
</tr>
<tr>
<td></td>
<td>71.6%</td>
</tr>
<tr>
<td>Total</td>
<td>7099</td>
</tr>
<tr>
<td></td>
<td>77.2%</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre

Table 4.6 shows the percentage of GPs who arrived in each time period for each of the South Asian countries. It shows that 52% of GPs trained in India, 22% of Pakistan, 62% of Bangladesh and 60% in Sri Lanka, all of whom had already arrived by 1992. These
distributions are illustrated graphically in Figure 4.7. The results show that while the percentage of Pakistan-trained GPs was the lowest in 1992, the bulk of their arrival (48%) in general practice appears to be in the period 2005-2009 whereas more than half of the GPs trained in India, Bangladesh and Sri Lanka had already been practising in 1992 and earlier.

Table 4.6: Percentages of GPs by Period of Entry for Each South Asian-trained GP group

<table>
<thead>
<tr>
<th>Period</th>
<th>South Asian-trained GPs</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>India</td>
<td>Pakistan</td>
<td>Bangladesh</td>
<td>Sri-Lanka</td>
<td>Total</td>
</tr>
<tr>
<td>1992 &amp; Earlier</td>
<td>3650</td>
<td>263</td>
<td>202</td>
<td>327</td>
<td>4442</td>
</tr>
<tr>
<td></td>
<td>51.4%</td>
<td>22.1%</td>
<td>62.0%</td>
<td>55.9%</td>
<td>48.3%</td>
</tr>
<tr>
<td></td>
<td>7.4%</td>
<td>4.5%</td>
<td>9.2%</td>
<td>18.5%</td>
<td>7.8%</td>
</tr>
<tr>
<td>1999-2004</td>
<td>1121</td>
<td>303</td>
<td>42</td>
<td>59</td>
<td>1525</td>
</tr>
<tr>
<td></td>
<td>15.8%</td>
<td>25.4%</td>
<td>12.9%</td>
<td>10.1%</td>
<td>16.6%</td>
</tr>
<tr>
<td>2005-2009</td>
<td>1802</td>
<td>572</td>
<td>52</td>
<td>91</td>
<td>2517</td>
</tr>
<tr>
<td></td>
<td>25.4%</td>
<td>48.0%</td>
<td>16.0%</td>
<td>15.6%</td>
<td>27.4%</td>
</tr>
<tr>
<td>Total</td>
<td>7099</td>
<td>1191</td>
<td>326</td>
<td>585</td>
<td>9201</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre
Figure 4.7: Period of Entry into General Practice by Country of Qualification

Source: The Health and Social Care Information Centre (n =69005)

Figure 4.8 shows the percentage of GPs who arrived in each time period for each of the South Asian countries between 2000-2009. It is very interesting to see that all bars in year 2000 are very small for each country, and then they start to rise. The NHS was hiring South Asian qualifiers again from 2001 and the chart reflects that hiring period, showing how much the proportion of each country in the total workforce increased over this decade. The Figure illustrates that while the proportion of GPs trained in Bangladesh and Sri Lanka has fluctuated and the proportion of Indian-trained GPs has been increasing, it is, the proportion of Pakistani-trained GPs that has shown the largest continuous increase within this group apart from a minor dip in 2007. The results show that 11.5% of GP’s entering General Practice in 2008 qualified in Pakistani when this Figure was 0.5% in 2000. The above migration pattern for the Pakistani-trained GPs is an interesting observation. A possible explanation is that as a result of increasing difficulties with the recruitment of
Indian-trained doctors, the new recruitment activity was geared towards Pakistan where political instability and Islamic fundamentalism may have served as a push factor for the doctors. The BBC News article mentioned earlier reported that BAPIO agreed to assist with the recruitment of doctors from India on the condition that the government allowed these new recruits to stay longer than the two year limit period currently in place, in order that the doctors could get the necessary training, that is, between three to four years. The article adds that BAPIO refused to help as the Home Office did not approve of the extended period of stay despite the fact that The Department of Health was supportive of the suggestion proposed by BAPIO. It adds:

*Dr Ramesh Mehta, the president of BAPIO, stressed the importance of allowing the Indian doctors enough time to get proper training in the UK, rather than simply use them to plug holes in rotas.*

**Figure 4.8: Percentages of South Asian-trained GPs in Each Time Period Between 2000-2009**

<table>
<thead>
<tr>
<th>Year</th>
<th>Pakistani</th>
<th>Indian</th>
<th>Bangladeshi</th>
<th>Sri Lankan</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>0.5</td>
<td>0.8</td>
<td>0.6</td>
<td>1.2</td>
</tr>
<tr>
<td>2001</td>
<td>6.4</td>
<td>3.6</td>
<td>5.5</td>
<td>2.9</td>
</tr>
<tr>
<td>2002</td>
<td>4</td>
<td>1.9</td>
<td>1.5</td>
<td>1</td>
</tr>
<tr>
<td>2003</td>
<td>6.4</td>
<td>3.5</td>
<td>2.1</td>
<td>1.2</td>
</tr>
<tr>
<td>2004</td>
<td>7.1</td>
<td>4.8</td>
<td>2.1</td>
<td>2.7</td>
</tr>
<tr>
<td>2005</td>
<td>8.2</td>
<td>5.2</td>
<td>2.8</td>
<td>2.4</td>
</tr>
<tr>
<td>2006</td>
<td>8.6</td>
<td>5.3</td>
<td>3.4</td>
<td>2.4</td>
</tr>
<tr>
<td>2007</td>
<td>8.2</td>
<td>4.9</td>
<td>3.4</td>
<td>2.1</td>
</tr>
<tr>
<td>2008</td>
<td>11.5</td>
<td>5.5</td>
<td>1.8</td>
<td>4.1</td>
</tr>
<tr>
<td>2009</td>
<td>11.4</td>
<td>4.5</td>
<td>4.6</td>
<td>4.6</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre (n=69005)
4.3.4 Demographic Characteristics and Geographic Distribution of the GPs

In this section, the individual characteristics of the GPs such as age, sex, GP type and geographical distribution of all five groups will be explored to see if there are any particular patterns across these groups.

4.3.5 Age Structure

In this section, I analyse the age structure of overseas-trained South Asian doctors and show how the pattern has changed over time. I compare the 1992 results which is the earliest period in the dataset with results from 2005-2009. The results are presented in Figures 4.9 and 4.10. The data shows the distribution of GPs from each group in four age groups. The 1992 results show strong differences in the age distributions of different country of qualification groups. The UK qualifiers are concentrated in the age group under 39 where almost half of their total workforce is located. As the age increases, their number starts to decline. Only 5.5% of the GPs in their group work in the age band ‘over 60’. Over 40% of the EEA group are concentrated in the age band ‘under 39’, like their UK counterparts the number starts to fall from thereon as age increases. In the South Asian group, only 3% of the GPs fall in the age band ‘under 39’, with the bulk of the South Asian GP population (87.9%) concentrated in the age bands 40-49 and 50-59, making them markedly older than all the other groups. Smith (1980) provides an explanation for the age differentiation between UK and overseas GPs stating that the strong tendency for overseas doctors to be much older than their UK counterparts is related to the fact that overseas doctors migrate after they have been working in the country of origin for some years; they also work in UK hospitals for many years before moving into General Practice and they are concentrated at the upper end of the middle age range. This also most likely reflects the pattern of migration as more South Asian doctors were recruited in the 1960s and 1970s than after this time. Doctors who were recruited in their 20s and 30s would thus be in their
40s or older by the 1992 data collection point. The UK-trained GPs tend to be younger when they enter General Practice as they can do this following the two year hospital service post medical qualification.

The majority of the GPs who trained in the developing countries are in the age band ‘under 39’ and 40-49. It has the highest number of GPs in the age band 40-49 in comparison with all other groups. This group also has a much larger group of over 60s than the UK-trained group. For the GPs trained in developed countries, the largest number of GPs is in the age band ‘under 39’ followed by a sharp decline in the remaining age groups. This group has a much larger percentage of GPs in the 60-64 age range in comparison with all the other groups.

**Figure 4.9: Age Band and Five Groups of GPs with Row Percent in 1992**

<table>
<thead>
<tr>
<th></th>
<th>under 39</th>
<th>40-49</th>
<th>50-59</th>
<th>over 60</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>49.9</td>
<td>29.2</td>
<td>15.4</td>
<td>5.5</td>
</tr>
<tr>
<td>EEA</td>
<td>40.6</td>
<td>23.7</td>
<td>15.1</td>
<td>15.4</td>
</tr>
<tr>
<td>South Asian</td>
<td>45</td>
<td>42.9</td>
<td>9.1</td>
<td>2.7</td>
</tr>
<tr>
<td>Developing</td>
<td>26.7</td>
<td>47.9</td>
<td>8.1</td>
<td>17.2</td>
</tr>
<tr>
<td>Developed</td>
<td>38.6</td>
<td>31.5</td>
<td>15.8</td>
<td>14.3</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre (n=29966)
The results for the period 2005-2009 are shown in Figure 4.10. The UK qualifiers are now more evenly distributed between the age bands ‘under 39; and ‘40-49’. The proportion of ‘under 39’ has decreased from 49.9% in 1992 to 33.2% in the period 2005-2009. The proportion of under 39’s has also decreased for the EEA-trained GPs moving from 40.6% in 1992 to 28.6% in 2005-2009. The largest proportion of EEA-trained GPs is among those aged 40-49 whereas previously it was in the ‘under 39’ group. For the South Asian group, the number of GPs ‘under 39s’ has increased from 3% in 1992 to 23.6% between 2005-2009, while the number of ‘over 60s’ has also increased from 9.1% to 35.3% showing the highest proportion in all five GP groups. This is the earlier cohort who were of the ‘40-45’ age band in 1992 now reaching retirement age, an issue that has been the cause of concern in the context of recruitment and retention of the UK GP workforce (Taylor and Esmail, 1999). The number of developing countries-trained GPs have increased from 26.7% in the ‘under 39’ group in 1992 to 33.5% between 2005-2009 whereas this number has dropped for the GPs who trained in developed countries from 38.6% in 1992 to 31.5% between 2005-2009. It appears that the GPs who trained in South Asian countries are the only group for which there has been a dramatic increase in the ‘under 39s’ age band since 1992. This reflects the fact that the NHS was actively recruiting newly qualified South Asian GPs in 2005-2009, so a new cohort of young GPs from these countries duly arrived.
4.3.6 Trends in Each South Asian-trained Group

Further analysis was carried out to examine the differences within the South Asian-trained GPs. Figure 4.11 shows that all the groups tended towards the middle age band in 1992, but Pakistanis and Bangladeshis tended to be rather older, Indians younger, and Sri Lankans showing a mixed distribution, with more young and very old GPs.
Figure 4.11: Age Distribution of South Asian-trained GPs in 1992

Source: The Health and Social Care Information Centre  (n=4442)

Figure 4.12 shows the age distribution pattern for the more recent time period 2005-2009. The proportion of GPs ‘under 39’ has increased in all groups except for those GPs who trained in Sri Lanka. The numbers of Pakistani-trained GPs has increased significantly in the age band ‘under 39’ from 1.5% in 1992 to 30.3%, similarly, the ‘over 60s’ have increased from 8.4 to 26.8%.

The proportion of Indian-trained GPs ‘over 60s’ is larger than those Pakistani-trained GPs. The Bangladeshi-trained GPs have an even higher proportion, that is, with 58.6% of their GPs concentrated in the age range over 60s. The bulk of Sri Lankan-trained GPs for this period are in the age band ‘50-59’ and ‘over 60s’.
4.3.7 Sex Ratio of GPs

In this section, I examine the sex ratio of all GPs in the UK. Table 4.10 shows the trends for the five yearly period 1992-2009. For the period 1992 and earlier, female GPs accounted for 27.5% of the total GP workforce, however, this almost doubled among new entrants in the period 1993-1998 and from there on it gradually increased reaching 56.5% in the period 2005-2009.
Table 4.7: Sex Distribution of all GPs in 1992

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>8246</td>
<td>6555</td>
<td>7433</td>
<td>7298</td>
<td>29532</td>
</tr>
<tr>
<td></td>
<td>27.5%</td>
<td>52.7%</td>
<td>54.3%</td>
<td>56.5%</td>
<td>42.8%</td>
</tr>
<tr>
<td>Male</td>
<td>21720</td>
<td>5875</td>
<td>6252</td>
<td>5626</td>
<td>39473</td>
</tr>
<tr>
<td></td>
<td>72.5%</td>
<td>47.3%</td>
<td>45.7%</td>
<td>43.5%</td>
<td>57.2%</td>
</tr>
<tr>
<td>Total</td>
<td>29966</td>
<td>12430</td>
<td>13685</td>
<td>12924</td>
<td>69005</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre

Figure 4.13 shows the proportions of newly entered female GPs among all five region groups. To simplify the results, they are presented for the period 1992 and earlier, and 2005-2009 rather than every year. There are similar proportions of female GPs among UK, EEA and developing countries-trained GPs in the period 1992 and earlier. The proportion among South Asian-trained GPs in 1992 is markedly greater than any other group – with four male GPs for every female. The South Asian-trained GPs have the lowest female representation while the developed countries have the highest female representation of all groups. For doctors entering the data set in the period 2005-2009, there has been a dramatic increase in the proportion of female GPs in all the groups and for the UK this proportion more than doubled from 29% in 1992 to 62.5%. The number of female GPs among the South Asian-trained and developing countries has also increased; however, despite this, they only represent 45% of GPs in each group. For the developed countries, there has been a moderate increase in the female representation from 40% in 1992 to 53.2% in the period 2005-2009.
Figure 4.13: Percentage of Newly Entered Female GPs Across Five Groups Between 1992-2005

<table>
<thead>
<tr>
<th></th>
<th>UK</th>
<th>EEA</th>
<th>SA</th>
<th>Developing</th>
<th>Developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>29</td>
<td>27.1</td>
<td>20</td>
<td>23.7</td>
<td>40</td>
</tr>
<tr>
<td>2005-2009</td>
<td>62.5</td>
<td>52.9</td>
<td>45.6</td>
<td>45.3</td>
<td>53.2</td>
</tr>
</tbody>
</table>

(n=29966 in 1992, n=12924 in 2005-2009)

Source: The Health and Social Care Information Centre

Figure 4.14 shows the breakdown of South Asian-trained GPs within this group by sex. There has been an increase in the proportion of female GPs across all the individual South Asian groups, however, some have shown a greater increase than others. Pakistani-trained GPs increased from 11% in 1992 to 41%, Sri Lankan-trained GPs increased from 17% to 52% between 2005-2009. Bangladeshi-trained GPs have had the least increase in their female representation since 1992. The under-representation of female migrants from South Asia may be related to the fact that there are far fewer female doctors than male doctors in the countries of origin or migration may not be as smooth a process for female migrants as
male migrants. Raghuram (2006) points out that, despite the fact that General Practice appears to be a preferred option for women doctors in the NHS, migrant women have their options restricted as they are subject to immigration laws; migrant women cannot enter General Practice until they have the right to stay in the UK. This is due to the fact that if they come to the UK as spouses of doctors; it takes longer for them to have the right to stay. Raghuram also states that, since 1979, only overseas doctors with a right of residence in the UK have been allowed to enter General Practice and later in 1985, this restriction also applied to locum posts, that is, short-term temporary posts.

**Figure 4.14: Percentages of Newly Entered Female GPs Across South Asian-trained Group**

<table>
<thead>
<tr>
<th></th>
<th>Indian</th>
<th>Pakistani</th>
<th>Bangladeshi</th>
<th>Sri-Lankan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>28</td>
<td>11</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>2005-2009</td>
<td>47</td>
<td>41</td>
<td>27</td>
<td>52</td>
</tr>
</tbody>
</table>

(n=4442 in 1992, n=2517 in 2005-2009)

Source: The Health and Social Care Information Centre
4.4 The Geographical Distribution of GPS

The analysis for determining the geographical distribution of various groups of GPs in Strategic Health Authorities (SHAs) over the years has not been without difficulties. The data prior to 1997 is not available for distribution of GPs in SHAs. The analysis further revealed that due to several re-organisations in the NHS for the period 1992-2009, the task of determining the geographical distribution of GPs was going to be challenging, as can be seen from the following table. The data for 1997-2000 has 105 local health authorities; however, one advantage is that they can provide some information about the characteristics of the individual health authority such as via an Indices of Multiple Deprivation (IMD) score and the ethnic composition of the local authority. The drawback is that this is only a crude measure as there are more and less deprived areas within a local authority as well as different levels of ethnic density.

**Figure 4.15: Number of Strategic Health Authorities during 1997-2009**

![Bar chart showing number of Strategic Health Authorities from 1997 to 2009](chart.png)

Source: The Health and Social Care Information Centre
The results show striking variations in the geographical distribution of GPs. To simplify the presentation of such a large quantity of data, two regions have been tabulated, one showing the highest concentration and the second the lowest concentration of South Asian qualifiers.

Table 4.8 shows the results for the Strategic Health Authorities where South Asian-trained GPs have the highest concentration. It is interesting to note that some Strategic Health Authority areas have as high as 54% concentration of South Asian GPs, for example, Barking and Havering. The majority of the regions in this table are deprived areas with large ethnic minority populations such as Birmingham, Liverpool, Manchester, Croydon and Rochdale, but, there are also deprived areas where the ethnic density is very low such as Gwent, Dyfed, Barnsley, and Doncaster. One possible explanation for this high concentration may relate to the recruitment difficulties in certain areas which have created opportunities for the South Asian qualifiers. Taylor and Esmail (1999) undertook a retrospective analysis of census data on GPs and concluded that the departure of many of the GPs from South Asia who emigrated in the 1960 and 1970s and who have been working as GPs will have implications for the workforce as the greatest number of such GPs had been in the health authorities in the most deprived areas of the UK and had which experienced recruitment difficulties in the past. Samers (2010) refers to this spatially uneven pattern as the socio-professional downgrading of overseas doctors in the NHS, as only 12% of these doctors were located in London and Southeast England (Williams et al., 2004).
Table 4.8: Health Authorities with the Highest Percentage Concentration of South Asian-trained GPs between 1998-2001

<table>
<thead>
<tr>
<th>Strategic Health Authorities</th>
<th>1998 %</th>
<th>1999 %</th>
<th>2000 %</th>
<th>2001 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking &amp; Havering</td>
<td>53</td>
<td>54</td>
<td>52</td>
<td>50</td>
</tr>
<tr>
<td>Walsall</td>
<td>52</td>
<td>51</td>
<td>48</td>
<td>48</td>
</tr>
<tr>
<td>Sandwell</td>
<td>42</td>
<td>42</td>
<td>40</td>
<td>36</td>
</tr>
<tr>
<td>Redbridge &amp; Waltham Forest</td>
<td>38</td>
<td>38</td>
<td>37</td>
<td>34</td>
</tr>
<tr>
<td>South Essex</td>
<td>36</td>
<td>35</td>
<td>35</td>
<td>31</td>
</tr>
<tr>
<td>East London &amp; The City</td>
<td>36</td>
<td>35</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>Brent</td>
<td>34</td>
<td>35</td>
<td>36</td>
<td>31</td>
</tr>
<tr>
<td>Bexley &amp; Greenwich</td>
<td>33</td>
<td>31</td>
<td>32</td>
<td>21</td>
</tr>
<tr>
<td>Wolverhampton</td>
<td>32</td>
<td>29</td>
<td>29</td>
<td>28</td>
</tr>
<tr>
<td>Enfield &amp; Haringey</td>
<td>36</td>
<td>35</td>
<td>34</td>
<td>Not known</td>
</tr>
<tr>
<td>East Lancashire</td>
<td>29</td>
<td>28</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>Wolverhampton</td>
<td>32</td>
<td>29</td>
<td>29</td>
<td>28</td>
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<tr>
<td>East Lancashire</td>
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<td>28</td>
<td>25</td>
</tr>
<tr>
<td>North Staffordshire</td>
<td>28</td>
<td>28</td>
<td>28</td>
<td>27</td>
</tr>
<tr>
<td>Barnsley</td>
<td>28</td>
<td>27</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>Wigan &amp; Bolton</td>
<td>28</td>
<td>27</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>28</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>South Humber</td>
<td>27</td>
<td>27</td>
<td>26</td>
<td>28</td>
</tr>
<tr>
<td>West Pennines</td>
<td>27</td>
<td>26</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>Ealing, Hammersmith &amp; Hounslow</td>
<td>26</td>
<td>24</td>
<td>23</td>
<td>21</td>
</tr>
<tr>
<td>Liverpool</td>
<td>26</td>
<td>25</td>
<td>23</td>
<td>22</td>
</tr>
<tr>
<td>Gwent</td>
<td>26</td>
<td>25</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td>Birmingham</td>
<td>25</td>
<td>23</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>Doncaster</td>
<td>25</td>
<td>24</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>Coventry</td>
<td>24</td>
<td>22</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Croydon</td>
<td>23</td>
<td>23</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>Manchester</td>
<td>22</td>
<td>22</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Bury &amp; Rochdale</td>
<td>22</td>
<td>20</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>Lambeth, Southwark &amp; Lewisham</td>
<td>22</td>
<td>19</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Merton, Sutton &amp; Wandsworth</td>
<td>22</td>
<td>21</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>Calderdale &amp; Kirklees</td>
<td>21</td>
<td>20</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>Salford &amp; Trafford</td>
<td>21</td>
<td>20</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Rotherham</td>
<td>22</td>
<td>21</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>West Kent</td>
<td>23</td>
<td>22</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Bexley &amp; Green</td>
<td>33</td>
<td>31</td>
<td>32</td>
<td>21</td>
</tr>
<tr>
<td>Birmingham</td>
<td>25</td>
<td>23</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>St Helens &amp; Knowsley</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>24</td>
</tr>
<tr>
<td>South Lancashire</td>
<td>23</td>
<td>23</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>Bro Taf</td>
<td>19</td>
<td>18</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>East Riding</td>
<td>19</td>
<td>19</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>Bromley</td>
<td>18</td>
<td>16</td>
<td>17</td>
<td>Not known</td>
</tr>
<tr>
<td>North Nottinghamshire</td>
<td>18</td>
<td>18</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>Gateshead &amp; South Tyneside</td>
<td>17</td>
<td>15</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Dudley</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>North Cheshire</td>
<td>17</td>
<td>16</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Barnet</td>
<td>15</td>
<td>13</td>
<td>13</td>
<td>22</td>
</tr>
</tbody>
</table>


Source: The Health and Social Care Information Centre
Table 4.9 shows the SHAs where the South Asian-trained GPs were least represented. The percentage ranges between 0.0 to 5 per cent. These health authorities are mostly in regions with low ethnic density such as Cornwall, Avon, Cambridge, Dorset and Somerset. The figures for these authorities appear to have remained steady over time except in Cambridge and Huntington where the proportion rose from 0.1 to 4% in 2001.

Table 4.9: Health Authorities with the Lowest Percentage Concentration of South Asian-trained GPs between 1998-2001

<table>
<thead>
<tr>
<th>Strategic Health Authorities</th>
<th>1998 %</th>
<th>1999 %</th>
<th>2000 %</th>
<th>2001 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cornwall &amp; Isles of Scilly</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>North &amp; East Devon</td>
<td>0</td>
<td>0.3</td>
<td>0.3</td>
<td>0</td>
</tr>
<tr>
<td>Cambridge &amp; Huntingdon</td>
<td>0.1</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Gloucestershire</td>
<td>0.5</td>
<td>0.5</td>
<td>0.7</td>
<td>1</td>
</tr>
<tr>
<td>Oxfordshire</td>
<td>0.7</td>
<td>0.7</td>
<td>0.9</td>
<td>0.7</td>
</tr>
<tr>
<td>North Yorkshire</td>
<td>0.8</td>
<td>0.7</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Avon</td>
<td>1</td>
<td>1</td>
<td>0.9</td>
<td>0.7</td>
</tr>
<tr>
<td>Dorset</td>
<td>1</td>
<td>0.8</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>North &amp; Midhampshire</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>North Cumbria</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>East Surrey</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Wiltshire</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Worcestershire</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Morecambe Bay</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Suffolk</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Portsmouth &amp; South East Hampshire</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>Not Known</td>
</tr>
<tr>
<td>Dyfed Powys HA</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>East Sussex, Brighton &amp; Hove</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Somerset</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>South Cheshire</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>West Surrey</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Northumberland</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Isle of White</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>East &amp; North Hertfordshire</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Newcastle &amp; North Tyneside</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre

That the results show a clustering of South Asian GPs in certain areas as can be seen. I was interested in exploring as to which health authorities the newly entered South Asian-trained
GPs have moved into. I chose the Pakistani-trained group as their number has increased significantly in recent years, as discussed earlier and carried out an analysis for Pakistani-trained GPs who entered the workforce for the first time in 2001. I selected the the period of 2001 as the number of Pakistani-trained GPs rose considerably from 6 in 2000 to 76 in year 2001. A cross tabulation between Pakistani-trained GPs in year 2001 with SHAs showed that almost all new entrants went to SHAs where there was already a high concentration of South Asian-trained GPs and established networks.

Table 4.10 shows a summary of Pakistani distribution in areas where more than one GP was employed in the same year. The figure in brackets shows the existing number of South Asian GPs in the area. West Sussex is the only area with few established networks for South Asian-trained GPs in comparison with all the other health authority areas listed in the table.

### Table 4.10: Number of Newly Entered Pakistani-trained GPs in 2001

<table>
<thead>
<tr>
<th>Strategic Health Authorities</th>
<th>No’ of Entrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley Bromley &amp; Greenwich</td>
<td>3(32)</td>
</tr>
<tr>
<td>Birmingham</td>
<td>5(22)</td>
</tr>
<tr>
<td>Brent &amp; Harrow</td>
<td>2(31)</td>
</tr>
<tr>
<td>Bury &amp; Rochdale</td>
<td>2(20)</td>
</tr>
<tr>
<td>Calderdale &amp; Kirklees</td>
<td>2(18)</td>
</tr>
<tr>
<td>Ealing, Hammersmith &amp; Hounslow</td>
<td>3(23)</td>
</tr>
<tr>
<td>Lambeth, Southwark &amp; Lewisham</td>
<td>3(19)</td>
</tr>
<tr>
<td>Redbridge &amp; Waltham Forest</td>
<td>3(37)</td>
</tr>
<tr>
<td>South Essex</td>
<td>3(36)</td>
</tr>
<tr>
<td>West Kent</td>
<td>3(21)</td>
</tr>
<tr>
<td>West Pennines</td>
<td>2(25)</td>
</tr>
<tr>
<td>West Sussex</td>
<td>2(3)</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre (n=76)
4.4.1 Patterns of Geographical Location for GP Practices within South Asian-trained Group

The analysis of the South Asian-trained GP group shows a pattern of clustering in their geographical distribution which can be observed among all individual South Asian-trained GP groups. Tables 4.11-4.14 show a clustering in those health authorities for which there were the largest numbers of newly entered GPs in the workforce among Indian-trained GPs in 2001. Smith (1980) observed that overseas-trained doctors were more likely to be working within conurbation areas which were ethnically dense. This study will explore how such clusters have been formed.

Table 4.11: Patterns of Clustering Among Indian-trained GPs in 2001

<table>
<thead>
<tr>
<th>Practice Location Areas in HA</th>
<th>India</th>
<th>Pakistan</th>
<th>Bangladesh</th>
<th>Sri Lanka</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wigan &amp; Bolton</td>
<td>66</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>234</td>
</tr>
<tr>
<td>North Staffordshire</td>
<td>62</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>188</td>
</tr>
<tr>
<td>Liverpool</td>
<td>59</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>227</td>
</tr>
<tr>
<td>Leicestershire</td>
<td>56</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>507</td>
</tr>
<tr>
<td>Sandwell</td>
<td>54</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>111</td>
</tr>
<tr>
<td>East Riding &amp; Hull</td>
<td>53</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>275</td>
</tr>
<tr>
<td>Barnsley</td>
<td>33</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>93</td>
</tr>
<tr>
<td>Berkshire</td>
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</tr>
<tr>
<td>South Humber</td>
<td>48</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>134</td>
</tr>
<tr>
<td>Calderdale &amp; Kirklees</td>
<td>42</td>
<td>9</td>
<td>4</td>
<td>1</td>
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</tr>
<tr>
<td>Manchester</td>
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<tr>
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<td>273</td>
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<tr>
<td>Leeds Health CARE</td>
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<td>0</td>
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<td>450</td>
</tr>
<tr>
<td>Sunderland</td>
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<td>0</td>
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<td>126</td>
</tr>
<tr>
<td>Wolverhampton</td>
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<td>2</td>
<td>3</td>
<td>1</td>
<td>101</td>
</tr>
<tr>
<td>County Durham &amp; Darlington</td>
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<td>3</td>
<td>1</td>
<td>343</td>
</tr>
<tr>
<td>North Wales</td>
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<td>1</td>
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<td>418</td>
</tr>
<tr>
<td>Cambridgeshire</td>
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<td>0</td>
<td>1</td>
<td>466</td>
</tr>
<tr>
<td>East Surrey</td>
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<td>0</td>
<td>0</td>
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<td>275</td>
</tr>
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</table>

(n=2953)

Source: The Health and Social Care Information Centre
Table 4.12: Patterns of Clustering Among Pakistani-trained GPs in 2001

<table>
<thead>
<tr>
<th>Practice Location Areas in HA</th>
<th>Pakistan</th>
<th>India</th>
<th>Bangladesh</th>
<th>Sri Lanka</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>24</td>
<td>106</td>
<td>3</td>
<td>5</td>
<td>527</td>
</tr>
<tr>
<td>Bury &amp; Rochdale</td>
<td>17</td>
<td>25</td>
<td>2</td>
<td>0</td>
<td>190</td>
</tr>
<tr>
<td>East Lancashire</td>
<td>15</td>
<td>59</td>
<td>2</td>
<td>0</td>
<td>226</td>
</tr>
</tbody>
</table>

(n=388)

Table 4.13: Patterns of Clustering Among Bangladeshi-trained GPs in 2001

<table>
<thead>
<tr>
<th>Practice Location Areas in HA</th>
<th>Bangladesh</th>
<th>India</th>
<th>Pakistan</th>
<th>Sri Lanka</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>East London &amp; the city</td>
<td>16</td>
<td>104</td>
<td>9</td>
<td>5</td>
<td>313</td>
</tr>
<tr>
<td>Barking &amp; Havering</td>
<td>11</td>
<td>74</td>
<td>11</td>
<td>5</td>
<td>101</td>
</tr>
<tr>
<td>Lambeth, Southwark &amp; Lewisham</td>
<td>8</td>
<td>50</td>
<td>4</td>
<td>18</td>
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</tbody>
</table>

(n=162)

Table 4.14: Patterns of Clustering Among Sri Lankan-trained GPs in 2001

<table>
<thead>
<tr>
<th>Practice Location Areas in HA</th>
<th>Sri Lanka</th>
<th>India</th>
<th>Pakistan</th>
<th>Bangladesh</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merton, Sutton &amp; Wandsworth</td>
<td>18</td>
<td>36</td>
<td>13</td>
<td>4</td>
<td>334</td>
</tr>
<tr>
<td>Bexley Bromley &amp; Greenwich</td>
<td>17</td>
<td>59</td>
<td>6</td>
<td>3</td>
<td>328</td>
</tr>
<tr>
<td>Croydon</td>
<td>14</td>
<td>23</td>
<td>1</td>
<td>0</td>
<td>142</td>
</tr>
<tr>
<td>South Essex</td>
<td>12</td>
<td>76</td>
<td>14</td>
<td>5</td>
<td>244</td>
</tr>
<tr>
<td>West Kent</td>
<td>12</td>
<td>90</td>
<td>14</td>
<td>3</td>
<td>473</td>
</tr>
<tr>
<td>Ealing, Hammersmith &amp; Hounslow</td>
<td>10</td>
<td>74</td>
<td>7</td>
<td>4</td>
<td>353</td>
</tr>
<tr>
<td>Brent &amp; Harrow</td>
<td>9</td>
<td>77</td>
<td>13</td>
<td>1</td>
<td>231</td>
</tr>
<tr>
<td>Kensington, Chelsea &amp; Westminster</td>
<td>6</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>247</td>
</tr>
</tbody>
</table>

(n=247)

Tables 4.12-4-14 Source: The Health and Social Care Information Centre

4.5 Analysis of Case Study Areas

Manchester, Sheffield and Barnsley were selected for their contrasting characteristics, including a major urban area, a large urban area and a relatively rural area. An analysis was carried out to examine the number of South Asian-trained GPs in each of the case study areas in 2001. This was due to the fact that after 2001, the individual areas cannot be identified in the data due to subsequent re-organisation of the NHS. Cross tabulation results of country of qualification, SHA and the year 2001 show that there were 32 South
Asian qualifiers in Sheffield, 55 in Manchester and 37 in Barnsley. The next step was to determine the age range so as to ensure that the sample had sufficient numbers in the 50 plus age range which was targeted.

Cross tabulation results of GPs and SHAs for the three areas are shown in the following graphs for 2001. Figures 4.15, 4.16 and 4.17 show the actual number of South Asian-trained GPs in Barnsley, Sheffield and Manchester who are likely to be in the database and show that there are 36 overseas-trained south Asian doctors in Barnsley, 28 in Sheffield and 52 in Manchester. This means that the case study areas are valid areas in which to undertake the interviews as there are sufficient numbers of South Asian-trained GPs.

**Figure 4.16: Number and Age of South Asian-trained GPs in Barnsley in 2001**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>No of doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-34</td>
<td>0</td>
</tr>
<tr>
<td>35-39</td>
<td>14</td>
</tr>
<tr>
<td>40-44</td>
<td>20</td>
</tr>
<tr>
<td>45-49</td>
<td>19</td>
</tr>
<tr>
<td>50-54</td>
<td>19</td>
</tr>
<tr>
<td>55-59</td>
<td>13</td>
</tr>
<tr>
<td>60-64</td>
<td>16</td>
</tr>
<tr>
<td>70 &amp; over</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: The Health and Social Care Information Centre
Figure 4.17: Number and Age of South Asian-trained GPs in Sheffield in 2001

Figure 4.18: Number and Age of South Asian-trained GPs Manchester in 2001

Source for figures 4.17-4.18: The Health and Social Care Information Centre
4.6 Summary of Key Findings from the Secondary Data Analysis

This chapter has considered the first research questions related to the investigation of the proportions of overseas-trained South Asian doctors in the UK GP workforce over the period 1992-2009. It has explored their demographics, employment location and how this pattern changed over time. The South Asian-trained GPs tended to be older than other group of GPs, male and pre-dominantly trained in India. The most basic difference between South Asian-trained GPs and the remaining groups lies in their distribution by number, age, sex and geographical location and that the former are clustered in areas that appear to be deprived and ethnically dense.

The number of overseas trained South Asian doctors grew from 4456 in 1992 to 5351 in 2009 and the number of new entrants has been rapidly increasing since the mid-2000s. For example, the more recent results from between 2005-2009 show that the percentage of new entrants among South Asian-trained GPs increased to 20% in comparison with 15% in 1992. The finding of their significant numerical presence in the early period when the NHS was expanding lends support to the argument presented by Simpson et al. (2010) that historical accounts have traditionally devoted little attention to the impact of overseas-trained doctors on the development of the NHS. Among the new entrants between 2005-2009, the proportion of UK qualifiers was the lowest in comparison with earlier years. This suggests that the demand for the recruitment of overseas doctors is likely to continue (Hann et al, 2008).

It is interesting, and disconcerting, that so many of the most recent South Asian recruits are from Pakistan whose migration can cause adverse effects in meeting the healthcare needs of that country’s population. Astor et al. (2005) state that the NHS has passed a Code of Practice (Department of Health, 2001) that does not allow recruitment of health professionals from developing countries which is reassuring, however, recruitment is
allowed if it is specifically agreed by the Department of Health in the sending country. Future research needs to explore this new trend in the medical migration of doctors of Pakistani origin and see if such measures protect the health systems of developing countries.

In the next chapter I consider the migration processes involved as well as the settlement of the overseas-trained south Asian doctors featured in the study.
Chapter 5: The Migration Process and Settlement

5.1 Introduction

In this chapter, I examine the empirical evidence that relates to part of research question four of this study that asked how the migration experiences of overseas-trained south Asian doctors related to the existing theories of migration. The chapter discusses the migratory processes leading up to settlement followed by discussion of how the overseas-trained South Asian doctors settled in their respective communities, and how identities are experienced in different contexts.

As explained in the literature review, various migration theories have been put forward to explain this sociological phenomenon. Since my research question relates to the investigation of the migratory process of overseas-trained South Asian doctors to the UK, I believe that the newly emerging Migration Systems Theory, which incorporates all dimensions of the migration experience incorporating the historical colonial link, has much to offer in analysing the complex sets of factors involved in the migration of overseas-trained South Asian doctors' migration into the UK (Castles and Miller, 2003). The approach adopted under this theory is based on a basic principle which assumes that a migratory movement is a consequence of the interaction of macro-micro-structures which are linked by a number of other intermediary agents known as meso-structures. The macro-structures are concerned with institutional factors, government policies etc whereas micro-structures relate to the motivation of individuals/groups and their social networks. The meso-structures consist of intermediaries (such as recruitment agents) which link the macro- and micro-structures (Castles and Miller, 2003).

This chapter provides detailed descriptive accounts of the interviewees’ journeys from migration to settlement which sum up the economic, social, political and cultural practices involved in the migration process. The data is organised thematically under the topics
relating to migration that emerged during the interviews. The process of migration will be discussed in the context of macro-micro-meso structures which will cover the reasons and mechanics of migration, for example, how the migration was facilitated, how social networks developed and were utilised, how the doctors negotiated the UK medical system, and how migration transformed into settlement.

The discussion within this chapter will explore how the empirical findings support the theoretical concepts proposed under the rubric of Migration Systems Theory and what the overseas-trained South Asian doctors’ own perceptions were in relation to the migration process. The following sections will discuss the mechanisms of migration that helped implement the migration plan of overseas-trained South Asian doctors in the study within context of the macro-, micro- and meso-structures stated above. Firstly, I will discuss the demographic characteristics of the doctors in the study.

5.2 Demographic Characteristics of the GPs in the Study

The interviewees were aged between 50-76. The majority of doctors were concentrated in the age band 60-75 which matched the profile derived from the secondary data analysis.

Table 5.1 shows the ethnic, gender and religious breakdown of doctors interviewed in each of the case study areas (also see Appendix 4). As can be seen, there are no overseas-trained doctors from Bangladeshi or Sri Lankan origin, this relates to fieldwork access issues in the case study areas. Given that community cohesion debates are increasingly concerned with religious identities in the UK, it was considered important to refer to religion in the analysis.
Table 5.1 Ethnic, Gender and Religious Breakdown of Doctors in the Case Study Areas

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
<th>Sheffield</th>
<th>Barnsley</th>
<th>Manchester</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Indian</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Pakistani</td>
<td>3</td>
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<tr>
<td>Total</td>
<td>11</td>
<td>8</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

5.2.2 Period of Migration to the UK

Figure 5.1 shows the year of arrival of the doctors in the UK in the case study sample. It appears that the majority of the early migrants from between 1962-1965 were of Pakistani origin (6/9) in comparison with their Indian origin compatriots (3/18). There are far more doctors who arrived in the 1960s compared with other periods; this migration is owed most likely to the fact that the NHS recruited around 18,000 doctors from the Indian sub-continent in the that period, as confirmed by BBC news.\(^8\) Another reason that may account for more numbers is the ease with which migration was possible as there was no immigration restriction on anyone coming from Commonwealth countries prior to 1962 (Panayi, 2010).

Figure 5.2 shows the breakdown of year of arrival for the interviewees in the case study areas. It can be seen that interviewees in Barnsley mostly arrived in the 1960s; and 1970s whereas Sheffield has a slightly higher proportion of doctors arriving in the 1960s; this may be due to the fact that Sheffield’s sample is slightly larger (11) than the other two areas. Manchester has the least number of doctors arriving in the 1960s. The settlement of the doctors in their respective areas was related to the opportunities available and working conditions being more conducive which will be discussed further in Chapter 7, together with reasons for how doctors became clustered in particular areas.
5.3 Macro-Structures

The macro-structures relate to institutional factors and include the laws, relationships and practices between sending and receiving countries that occurred in order to control migration settlement. They can act as lubricators in the migration process (Castles and Miller, 2003). A common route described for coming to the UK was by way of an application to the GMC for a recognised clinical attachment under the supervision of a UK consultant; this was offered for an initial period of four weeks. The following interviewee explains the process:

*I suppose if I want to apply for clinical attachment... my professor talks to your professor here and he says okay you send your boy here I will give him clinical attachment, it used to be a recognised training for 4 weeks, just to give exposure to the local system and they used to pay just nominal salary, some eighty pound or something for whole month period (gpm7).*

However, four of the Pakistani origin and three of the Indian origin doctors had come to
the UK prior to 1965 under the voucher scheme\textsuperscript{9} that was in operation at the time to overcome the labour shortage in Britain. The 1948 Nationality Act allowed Commonwealth citizens who were also British subjects a guaranteed right of entry to the UK. This ‘open door’ immigration policy remained in place until 1962 when it was replaced with a quota system which restricted admissions to those holding employment vouchers. As stated previously, historically, doctors came to the UK to gain a post-graduate qualification, and while immigration control was in existence for unskilled/low/semi skilled migrants from the Indian subcontinent countries, doctors were not subject to strict immigration control until 1994 (Robinson and Carey, 2000). Gish (1971) comments that the immigration acts of 1960 and early 1970 were intentionally designed so that the recruitment of new Commonwealth doctors was exempted from any restrictions while the majority of other non-professional potential migrants from these countries were excluded.

Six Indian origin doctors stated that they had undertaken a post-graduation qualification which exempted them from the clinical attachment requirement and had been given full registration status prior to coming to the UK. Their accounts show that they obtained jobs with relative ease in less prestigious specialties:

\textit{I was lucky also that err as I landed in London on Saturday morning.. err BMJ [British Medical Journal] we saw and there was a job[advertised] next door to my friend’s hospital, yes and he rang the hospital and they said okay come... ask him to come with his err documents and we’ll interview him and give him...}

\textsuperscript{9} The Commonwealth Immigration Act 1962 introduced employment vouchers, where anyone in possession had the right to enter and settle in Britain. There were three categories: A, B and C. The ‘A’ voucher was granted to those who had a specific job to come to and where the initiative had to come from the employer. The 'B' category voucher was issued to those who possessed recognised skills and qualifications that were in short supply such as medical; these were skills that were likely to be useful in the UK. The professionals included in this category were teachers, nurses, doctors, dentists, etc. All other unskilled applicants were included in the category ‘C’ (Doyal et al., 1981). Those who obtained vouchers could enter the UK provided they would work in areas with a labour shortage (Panayi, 2010)
it was a locum job... stopgap job, they gave me 10 weeks err locum job because somebody who took the job he became ill or he might have left the job and they couldn’t fill that job up for 10 weeks, yes they wanted somebody to join, lot of people started like doing short term jobs, in certain specialties it was easier, such as casualty, orthopedics... but not in Pediatrics, for example... (gpm7).

The above account highlights the significance of the role of social networks which is discussed later. The interviewees talked about how they had to meet the criteria which included qualifying from specified medical colleges, obtaining house jobs in specific specialties and being resident doctors in such specialties. These requirements were laid down by the GMC and the frequency with which clinical attachments were offered suggests that such screening undertaken was in fact an indirect recruitment process of doctors to work in the NHS rather than the intention of providing a learning opportunity for them. It is not known whether this type of indirect recruitment related to the circumvention of migration restrictions, or simply occurred because it was the most convenient mechanism for recruiting from South Asia. The interviewees stated that most of the time these clinical attachments were in disciplines and areas where there was shortage of doctors, with the four week attachment often extending to a short term contract with doctors being offered jobs in the same hospitals when a vacancy arose. These findings support Raghuram and Kofman’s observation (2002) that refers to the altering of state regulations both of immigration and those governing the medical labour force, to meet the specificities of internal labour-market shortages.

5.4 Micro-Structures and the Driving Forces of Migration to the UK

The micro-structures relate to the motivation of individuals/groups and their social networks. Micro approaches also relate to the processes underlying the decision to migrate and the influences that come to bear on the individual’s decision to migrate and the choice of destination (Stillwell and Congdon, 1991) on which this section will focus.
The doctors in the study highlighted various reasons for their migration; some of these were disclosed in response to direct questioning, others came to light during the more general discussions. This section, therefore, is divided into sub-sections that sum up the nuances and complex sets of factors involved in the motivation to migrate.

5.4.1 Gaining of Post-Graduate Qualifications and UK Medical Training

Almost all the doctors stated that their primary purpose for migration was to obtain a post-graduate medical qualification which linked with their career aspirations. Three out of four of the female doctors stated their main purpose was to support their spouses in the pursuit of higher education; however, they had also hoped to undertake some specific diplomas during their stay in the UK. Similarly one male doctor migrated to join his wife-to-be; however, he also stated that his motivation to undertake a postgraduate qualification. The interviewees emphasised that coming to the UK for post-graduation education was a well established practice in that era and that this was also a closer match in structure/qualifications to the South Asian medical system.

Several interviewees from both Indian and Pakistani origin talked about the perceived superiority of UK qualification in their countries of origin and the value that it adds to one’s human capital. There was some anticipation about the ensuing exposure to the high standards of education and training provided in Britain which was likely to enhance their status upon returning from migration. Below is a typical response in this area:

_I came to do an MSc and I wanted to specialise in medicine. I wanted to get experience in a UK hospital because this experience means a lot in Pakistan; everyone respects and is willing to offer you a job if you have experience from a British institution (gpb5)._

The majority of the doctors had specifically wanted to acquire fellowships from a British Royal College which they believed was highly valued in their countries of origin. This is the qualification that is required to become a consultant, whereas others had wanted to
obtain diplomas in specific specialties. These findings support the findings of earlier studies that overseas-trained doctors are more likely to have a career intention of progressing to the consultant grade in comparison to UK-trained doctors (Oikelome and Healy, 2007; Anwar and Ali, 1987; Smith, 1980; Esmail, 2007; Rashid, 1990).

The following doctor explained that he wanted to specialise in ENT (Ear Nose and Throat) and the resources were insufficient in the country of origin. It appears that long after the British left India, the medical profession continued to be influenced by them:

*There was post grad in India and I had taken part one for the fellowship, but there were not good prospects for my specialty, I was specialising in ENT. A British degree is always preferred, well at that time anyway (gp6b).*

Another interviewee stated that he wanted to specialise in gynaecology, however, he was discouraged by his professors as this specialty was not a norm for male doctors at the time in India. The interviewee below describes the migration decision being made on the spur of the moment; however, the account also reveals other factors and conditions influencing such a decision. The medical colleges were regularly visited by British medical personnel who acted as an inspiration for the overseas-trained South Asian doctors. It has been stated that the standards for medical education in India were set and regulated by the GMC to ensure compatibility for those Indian doctors who wished to work in Britain. The purpose of these visits from British professors may have been to ensure that the Indian medical colleges were adhering to British standards:

*What happened was that one of my friend said to me, I am thinking of going (to Britain), will you come, I said ok (laughs), so we came.....UK qualification is preferred especially in medicine. Our medical system was set up in the same way and everyone more or less came here to upgrade their education at some stage. Now, I hear that doctors go to Australia from India and Pakistan. In India, only UK fellowship was recognised, membership or FRCP, MRCP, which you could do in Britain, all of our professors had been educated from*
here and they had fellowship, membership from England. We also had British professors visiting our colleges on a regular basis (gp6b).

Decisions to migrate to particular countries were influenced according to the doctors' motivation at the time. Migration to the UK was associated with academic opportunities:

When I finished my house job, there had been invitations from USA and Britain for us, some of my colleagues went to USA but I chose Britain as I wanted to do FRCP, there was another choice, invitation from Saudi Arabia as well. You go to other countries for economic reasons but you come to Britain to do your post-graduation (gp2s).

The relevance of the medical education and training the physicians receive in the Indian sub-continent has been questioned for its relevance to the health needs of the majority of people as it has been modelled on the British medical education (Mej'ia, 1978; Esmail, 2007). The benefit to the less developed donor country of a postgraduate training undertaken in a technologically advanced country which has a highly specialised and capital intensive medicine has been also questioned. Mej'ia (1978) argued that a returning migrant physician is relatively unsuited to perform the tasks that are most needed in the developing countries. Esmail (2007) provides a different explanation and refers to the colonial context in which coming to Britain to study was considered like a badge of honour and upon return the migrant commanded considerable distinction in the Indian society. This practice, the author argues, has continued from 1800 to present day.

5.4.2 Professional Experience and Income

The ability to work with renowned professors and within prestigious hospitals in the UK, as well as to gain practical experience and clinical excellence were things that cropped up in numerous accounts, and were described as a tradition for those doctors migrating to the UK. The interviewees emphasised that broadening their horizons by learning new ways of practising medicine and eventually taking these skills back home, was their primary objective. Although the interviewees did not refer to themselves as economic migrants, the
following doctor explains how his friend inspired him to come to the UK as he talked about his success in the country:

This was 1965, before war, so I received the voucher, my friend H had already come, he wrote to me and said that he had already got provisional registration and that he worked in a hospital A & E department [Accident and Emergency]. He also said, I earn between 100-150 rupees (£10-£15) a month whereas he earnt that much in a week. He said I should come to UK (gp2s).

The above illustrates how migration can become a self-perpetuating general system if it impacts positively on the migrant. Satisfaction with the move is communicated back to friends and relatives of the migrant in the sending countries which may lead to a process of chain-migration (White and Woods, 1980). Many interviewees mentioned that they had been influenced by others’ success stories. Being financially supported during post qualification training was also mentioned by a few others as an incentive for migrating to the UK which also suggests an economic context as a pull factor for migration. Doyal et al. (1980) argue that upon completing vocational training in India and Pakistan, many new graduates were being targeted by the countries with medical staff shortages; Britain was one of these countries. The UK qualification was described as acting as a subsequent guarantee for better job prospects in the country of origin, providing a wider choice of branches within medicine than the Indian system:

By and large, the well established concept the ‘Brain Drain’ is associated with the one way movement of highly-skilled professionals such as doctors from developing countries to developed countries (Pang et al., 2002). The doctors’ accounts show that intended outcome was ‘Brain Gain’ where knowledge is taken back to the home country:

...Oh that you wanted perhaps to broaden your horizon, improve your qualifications, and see how medicine is practiced in one of the best, I still say today that the National Health Service, it still is the envy of the world and that you want to see how health, universal healthcare is provided in the most
reputable hospitals in the world and then you wanted to learn from this aspect and once if that could be somehow be implemented back home (gpm8).

The following interviewee’s account sums up the push factors for his migration which include poor working conditions, lack of training opportunities, medical training not geared to meet the needs of physicians and patients. It would appear from his account that he sees the UK system as superior:

There was no improvement in the system, no changes, there is corruption, in hospitals, in all fields including NHS, everywhere, there are no facilities, there is no educational training programmes, we have got NHS service in Kashmir but it could be better if there were other facilities and educational programmes e.g. when I came here I had to go for GP training for three years, The system here is so well developed. Over there we were trained for something that we didn’t have, the equipment, the training, the whole system (gpa8).

The above accounts provide evidence of the specific colonial contribution in this area through institutional linkages, and the prestige associated with the profession, by downgrading the Indian medical system. The interviewee refers to feeling ‘left high and dry’ by the western model of medical education with its lack of relevance to the needs and systems of countries on the Indian subcontinent (Esmail, 2007, 828). Others were of the opinion that Britain was a just society:

They (teachers) said that the system is a lot fairer here and that one does not need to be acquainted with some high powered minister or his relatives to get a job (gpa6).

The perception of fairness relates to the individual positive experiences which migrants relay back, constantly comparing them with their experiences in the country of origin without analysing the wider context in which they take place. For example, the same interviewee later stated that he was ‘headhunted’ by a British professor who imported him to work in a British hospital as he was the best in his specialty. He was lacking in the
support networks crucial for migration and had no means to migrate otherwise; therefore his perception of the British being fair possibly developed from his conditioning in English medium schooling was subsequently reinforced by his actual experiences. Ironically, his later experiences in the UK when he was not able to penetrate the ‘glass ceiling’ that he and many other doctors in the study described as preventing them from progressing to consultants’ roles, do not appear to have negatively impacted on his views concerning Britain; his failure to look at the bigger picture and how structural inequalities impacted on the career progression of overseas-trained South Asian doctors may be related to the values embodied by the NHS. There was evidence of this where the negative experiences were silenced or underplayed. I will return to an analysis of why this may be the case later.

Ambiguity about the relevance of the UK postgraduate qualification in the country of origin also surfaced in a few interviewees’ accounts:

> Another thing, you are exposed to the different way of practising. Developed countries have got different ways of doing the things especially UK, and if you have firsthand experience and you can translate that thing back into your country when you go back, and you can improve your services also, but it may suit to that country or not I don’t know, because our way of teachings are different, our way of... our cultures are different, we go with the religious views, we go with caste culture there are so many things you know, people go out of the country to get experience that is the main reason people go out (gpm7).

The interviewees’ accounts clearly show their passion for learning and knowledge and for the medical profession. The colonial historical context previously discussed may explain the urge of the doctors in the study to invest in their human capital by acquiring a western education which would promise them social status in a prestigious profession such as medicine (Husband, 1982)


5.4.3 Fascination with Britain: A Colonial Legacy

Explanations given by the interviewees such as ‘bettering’ themselves and accessing postgraduate training opportunities provided just minor visibility a more intricate scheme (Robinson and Carey, 2000). The individual stories unravelled subtle factors that appear to have played a key role in migration decisions such as fascination with Britain as a place. As previously stated, the interviewees’ exposure to English medium-stage schools shows how they had been conditioned to think of Britain in a positive way:

*We had heard a lot about Britain in schools. We had an image of Britain as nice and clean, like a paradise on earth, country. My wife and I had only just qualified and got married; we wanted to see the country that our parents and their parents used to talk about (gp3b).*

*I went to an English school and read all about Britain from a young age, poetry, prose, Shakespeare, Wordsworth and I was always curious what this beautiful country looked like, you see, so I always wanted to come and see for myself what it looked like (gp4b).*

A few of the interviewees came from an army background where direct or indirect contact with the British had been inspirational for generations. Husband (1982) refers to the experiences of African Caribbean people who also felt a ‘legitimate bond’ with Britain, seeking membership here; indeed, long after the British had left India, Britain was still being remembered as the ‘Mother Country’.

The interviewees’ accounts related to the legacy of colonial relations which was personal, and emotional, as well as institutional (Robinson and Carey, 2000, 100). The above authors refer to their empirical study of Indian doctors in which colonial links figured strongly in the doctors’ accounts. The authors contend that decisions to migrate to ‘better themselves’ are based on economic as well as other non-economical ‘taken for granted than instrumental’ factors such as the kind of novels one reads as a child. The majority of the
interviewees in this study described how they had a pre-conceived image of the UK as a ‘paradise’. Their accounts provide evidence of how an English medium-stage education, the school curriculum and the role of missionaries led to the mythologisation of England and impacted on their social lives as ex-colonised people. This impact is likely to be particularly strong for those towards the top of the status hierarchy which most of these doctors were:

*I used to read a lot in my school days, I went to a school which was run by nuns. I knew all about Shakespeare.... I had an image of England as some kind of paradise... where everyone was so nice and friendly, everything clean and orderly (gp1b).*

It is interesting to note that the doctors in the study did not reflect in the same way as the writers of *Unbecoming Daughters of the Empire*, that is they did not acknowledge acknowledging the impact of colonialism. This difference in reflection may be owed to the fact that the sharing of individual stories was the outcome of a specific collective post-colonial literary project where women may have felt empowered to articulate their experiences. This may also relate to the fact that identities are experienced differently by individuals in different contexts. These identity related issues will be further explored in Chapter 7.

**5.4.4 The Role of the Family in the Migration Decision**

The majority (22/27) of the doctors described their social background as elite middle class as they came from well educated families. The doctors variously described the profession of their parents as teachers, psychologists, government officers, army officers and influential people in the community, with the exception of a couple of doctors from more modest backgrounds where their families belonged to farming communities. These doctors stated that their parents had worked very hard and ensured the best education for their children so that they could get on the social mobility ladder. Three of the Pakistani origin
doctors said they came from families where their fathers and grandfathers served in the army and had served in the British army. Only three out of the 27 doctors interviewed had prior familial links within the UK. The role of the family has been stated as central in migratory movement from the Indian sub-continent countries (Castles and Miller, 2003). Lahiri (2000, 39) also contends that obtaining a British qualification was rarely an individual choice, and that parental aspirations lay behind this enterprise, for they perceived it as a window of opportunity for their children and an English hallmark as a ticket to success.

Mixed evidence was found in this study concerning the role played by families in the migration decision. Two thirds of the interviewees confirmed that family had played a significant part in planning of move. They talked about how their parents and even grandparents had held aspirations for them to go to England for higher education in medicine to enhance their social status and fulfill what they described as ‘family honour’:

*My family, not just my parents but grandparents, uncles and aunts* had always said that they wanted one of their family members as a doctor because it raised your social standing in the community and if you were a UK qualified, this was even better for the family honour (gp1s).

The interviewees’ accounts show that the families with a religious background were no different and they all had similar aspirations for their sons:

*My father, although was a religious man, he had a strong Indian Muslim identity, he very much wanted one of us to do medicine and go to the UK to do higher education. You would be regarded as a highly respectable person in the Indian society if you had raised and educated a son who managed to get UK qualification in medicine. I was the one who fulfilled my father's ambition, but unfortunately, by the time this happened, he had passed away (gp7s).*
Views regarding migration emanating from among South Asian religions vary. While Muslims believe their religion supports travelling abroad for education (Sayeed, 2006), Hindu Brahmans vigorously oppose foreign travel (Lahiri, 2000, 39).

Robinson and Carey’s (2000) study also highlighted the significance of the notion of family honour (Izzet) in their findings and argue that the linkage between spatial, social mobility and Izzet is central in understanding migration from the Asian sub-continent. Sayeed (2006), in an autobiographical account, states that he fulfilled a heartfelt wish that his grandmother made four decades prior to him becoming a doctor and sixteen years prior to his birth.

Contrary to the much discussed role of family being central to the migratory process, migration might also be described as a solo act. As many as one third of the interviewees emphasised that migration had been solely their own decision. The account of the following interviewee also provides contrasting evidence regarding family support for migration:

"My plan was to go back to India eventually. You see my father hated me to come to Britain; in fact he did not even want me to study medicine because he was fearful that I would lose my Indian identity. He never liked the British. He wanted his all sons to be farmers but we had seen the other side you see, none of us wanted to do that, he used to say the British will corrupt your minds.(laughs). It was funny, he was pulling us to his Indian heritage and we wanted to see and work with those prestigious doctors and professors that we read about in books. I think that the British did us good in many respects and medicine is one example, they set up a good medical system in India (gp6s)."

The above account shows how the doctors had to deal with conflicting motives, on the one hand, a desire for status and professional advancement (either by themselves only or their family) and on the other, a desire to maintain their cultural identity and links to their homeland. It also shows how colonisation impacted two members within the same family
differently; one who believed in the anti-westernisation movement, and the other being directly influenced through medical education based on the western model. However, the laughter of the interviewee did indicate that he appreciated his father’s views as well. Lahiri (2000, 42) argues that it would be too simple to state that there was increasing rejection of the west in Indian society, as rejection and admiration of the west seem to co-exist. Others refer to this phenomenon as a direct result of colonialism which has left scars on the colonised (Chew and Rutherford, 1993).

5.4.5 Teachers as Role Models

According to Samers (2010), the causes of migration may be located in the social networks that communicate the value of a particular destination among migrants and connect structures, institutions and agents. Almost all the doctors talked about how they were influenced by their teachers, professors and consultants who were part of the medical establishment and who either originated from Britain or had been trained in UK hospitals and who had shared stories of their positive experiences. Within the Indian sub-continent cultures, the learner-teacher relationship is such that teachers’ are accorded a lot of respect for their wisdom, knowledge and expertise; they are looked upon as role models. The fact that the teachers made personal recommendations was meaningful for the students as illustrated in the following accounts:

*I came to the UK to, to advance my medical training, because people from UK, who trained in the UK, who were... came back to India, my consultant and professors, not all of them, a number of them.. they all, they all, were quite happy with the training they had so and so forth and when I was training to be...(gp2m)*

He adds that career discussions were a regular occurrence:

*...after my qualification and junior doctor we had talks like this... generally what we will do and where we will go for training and they particularly said if*
you want to train abroad UK is the place to go because it’s the training is pretty good and it’s... as far as medicine and surgery is concerned it’s a... very methodological and it’s done properly and it’s a good experience (gp2m).

The teachers thus played a significant role in reinforcing the superiority of a British education and professional experiences in the UK as well as providing information about migration opportunities aiding with preparation for the migratory process. The interviewees’ accounts show that their teachers had wholeheartedly embraced the British medical model which was imposed upon India during colonisation. The role played by the teachers is an important example of the colonial institutional legacy, and its effects upon the shaping of attitudes. The historical context of Indian Medical Services (IMS) described by Esmail (2007) provides an explanation for the influential role of the teachers as described by the interviewees.

5.4.6 Political/Social/Cultural Reasons

The cultural, social and political complexities of migration also surfaced in the interviewees’ accounts when discussing reasons for coming to Britain. Structural inequalities based on caste and class were cited as the most common reasons by interviewees of both Indian and Pakistani origin:

...you are only successful if you have ‘approach’ to the right (influential) people (gp5s).

The interviewees themselves acknowledged that there was no simple and single reason for their migration. However, among other things, lack of political freedom was cited as a motivating factor:

Main reason was very complex it’s not easy and straightforward...I think essentially it was a political reason, I was very much involved in student politics in college days, things became very difficult, it’s a very very difficult
time, so when you are involved in politics you are targeted, it was essentially a political. It was dangerous for me to remain there (gpm4).

Migrants sometimes return home when the primary goal has been achieved (Castles and Miller, 2003). A few of the interviewees who had returned after gaining post graduate qualification stated that their re-migration was due to political disturbances in their country of origin.

An Indian origin female stated how her husband could not obtain a post-graduate qualification in India due to political issues at the time:

"So when he applied for post-graduate, because he wanted to do Orthopedics, MSA in Orthopedics, three times he’s been turned down because he couldn’t write in Tamil. That was the main reason, so then we found there was no reason, no point in sticking to this place. I’m going to apply and go abroad [Refers to husband], that’s how it came about. He was born and brought up in Bombay, at that time; they did all this unnecessary unwanted rules and regulations (gp1b).

The instability of Indian and Pakistani politics in the migration and post-migration period was identified in one third of the interviewees’ accounts, with Britain valued as a potential ‘haven’. This type of behaviour was also witnessed in the colonial period, where some villagers were said to hold the British in great esteem as their rule had brought some ‘stability’ following the insecurity created by resistance and conflicts among the ruling Indian classes (Husband, 1982).

Apart from the influence of a western education, motivations for moving to the UK were also described in a cultural context. Culture can be defined in terms of language religion, and values (Castles and Miller, 2003). The findings of this study lend support to the assertion of Hagan and Ebaugh (2003) that the role of religion and spirituality in the stages of migratory process has been neglected by scholars of both immigration and the sociology of religion, despite its prominence in immigrants’ lives. The interviewees described how
they were influenced by revolutionary literary writings and Urdu poetry of their era. The following Pakistani origin interviewee explained this by reciting the following poetic verse which he said had been inspirational for him in his decision to migrate; it also indicates how his faith shaped his way of thinking:

> When I was young, I used to read this Urdu poetry which I found very inspirational:
> 
> Mohabat mujhe un jwanu se hey,
> Sitarun pa jo dalten hey Kama nd.

[Explains the meaning] The poet says, ‘I love those kinds of people who have the ability to capture stars by throwing a noose at them, what is meaningful here is that one must not make poverty or other problems as excuse, My own interpretation of this is that you try, God will then help (gp2s).

For gp2s, reaching out to the stars equated to coming to the UK which was considered a huge achievement in his era, and he proved that with a show of determination he was able to do what may have been undoable for many. An Indian origin doctor articulated similar views by reciting a different poetic verse that he had found inspirational with regard to migration:

> You see I was very much influenced by this poetry verse in my youth,
> 
> Tufan ki zindgi pe sadqe hazar janein
> muj ko gawara nahien sahil ki moat marna

What exactly it means is that I like storms because they bring challenges and I like to live a life which is challenging, challenge inspires you to do something, you are in the middle of a storm and you work hard to reach the seashore but after you reach the seashore, there is no more struggle left. Tufan [storm] is another name for doing something extra-ordinary and I would rather give thousand lives to a life that is spent in doing something to fight with injustices, I preferred to migrate than to sit helplessly and do nothing, but I also hoped to return one day (gpm8).

A third of the doctors in the study referred to the strong cultural influences and values that
they had been brought up with and which included the belief in takdir (destiny), that it is
*He who makes the plans and you are destined to it by your creator* (Sayeed, 2006). One
interviewee of the Hindu faith commented that his future was destined this way:

*It’s got to do with destiny; it’s not what you decide you would do* (gp2b).

Similarly, another interviewee explained that his Muslim faith provided guidance for him:

*We (as Muslims) believe that any migratory movement is a blessing for you*
*(harkat mein barkat hai). We come from a risk taking culture, its ingrained in
us, we took a huge journey, crossed many seas, just a few pounds in our
pockets, because we had faith in us, in our ability and hard work* (gp7b).

The migrants’ creative use of religion in the above quotes is clearly evident, not only in
their decision-making processes, but also with regard to its provision as a spiritual
resource. Their accounts show that the psychological effects of religious values resulted in
their commitment towards enduring the hardship of migration (Hagan and Ebaugh, 2003).

The findings show that causes of migration can be found in the cultural, political and social
marginalisation of specific groups of people (Samers, 2010). They add to our knowledge as
to how the doctors used creative ways forward, where aspects of culture, language, religion
and values, became integrated in the organisation of the migratory process.

**5.4.7 Professional and Elite Social Networks**

In this section, I will discuss the informal social networks that the migrants developed in
order to manage migration and settlement. As outlined in the literature review chapter,
chain migration has received a lot of attention in migration studies; it implies that social
ties that are based on kinship and community membership facilitate a process by which
migration leads to more migration. This terminology has been replaced with ‘migrant
networks’ which are defined as ‘interpersonal ties’ connecting key actors such as migrants,
former migrants and non-migrants in both origin and destination countries by means of
kinship, friendship and shared community origin (De Haas, 2010).
Researchers of migration studies associate the bulk of migration of South Asian origin people with networks that are based on kinship; however, the focus of such research has been peasant/low/unskilled migrants. The networks utilised by migrants vary considerably and a qualitative variation has been shown to exist in the types of networks that different occupational classes utilize. For example, unskilled migrants’ networks are likely to be based on kinship, whereas ‘high occupation groups’ tend to rely on their colleagues and institutions (Shah and Menon, 1999). The findings of this study bring to light the heterogeneous nature of networking utilised by the doctors in the study pre and post-migration. Very few of the interviewees had prior familial links in the UK. Two key institutional links were described by all the interviewees as providing information concerning migration, one being the medical colleges themselves, where teachers inspired students to travel to UK universities for exposure to professional experiences and technological advancements, as discussed in the previous section concerning the motivation to migrate, while the second instrumental institutional link described as the first port of call for these migrants was the GMC which provided key information as to what migrants had to do prior to and post-migration. This is very different to the networks typically discussed in chain migration, which are informal and community based. A couple of interviewees discussed utilising networks which can be classed as non-traditional links that had evolved. For example, one interviewee described how he had networked with a UK origin doctor with whom he had become a pen friend during his studies in Pakistan:

*When we were at college, we were encouraged to have contact with other medical students in Europe, our teachers used to say you must have links with Europe, then you will know what they are studying. I had a pen friend D in Somerset in the UK; I used to write to her regularly. She was very helpful, she could not come to meet me at the airport but told me about flights, hotels airport etc. I was a little nervous, new country; I did not know the country at all. She had also explained what I should do, like contact GMC and look for jobs in BMJ (gp2s).*
The above interviewee remarks how he was apprehensive about coming to a new country which was also mentioned by several others. Some interviewees had the belief that only those who have strong networks can migrate:

Most doctors who are able to come to the UK are from upper middle classes with well established links. I had no contacts or important links with anyone because I come from a farming community and was the first one to become a doctor. If I had not been headhunted by an English professor who had gone to our hospital where I was working, I probably wouldn’t have been able to make it (gp6s).

However, this belief is not borne out by the experiences of doctors from more privileged backgrounds. Only a few of the interviewees (4/27) described that in the initial period of migration, they had networked with friends and colleagues who were either from the same medical college or had occupied similar social/professional positions, and had been inspirational and facilitated the migration process. Emphasis was placed on long standing relationships between families and the social positions of the links, as the following response illustrates:

I had, yes I had a friend who was here for a few years before I came, a family friend, she’s a consultant in Obs & Gynae [Obstetrics & Gynecology], err and he [husband] was working in a hospital, yes they were helpful because when I arrived here they, they came and met me and then put me up with them for a few days until I moved on to Southampton and so on (gpm2).

The following doctor described how friends had facilitated his social mobility by providing employment links and introducing him to key contacts:

I had some doctor friends, they said what we can do is to introduce you to our consultants and then it is up to how you perform. They did introduce me to the consultants, let me stay with them for a week so that I could acclimatise and get used to things. I got an attachment in Kettering in Northamptonshire (gp1b).
The most frequent response however, was where interviewees reported that they did not know anyone when they came to the UK which may suggest social networks are less important for skilled professionals, a finding which is also referred by (Shah and Menon, 1999). Few talked about having some transient non-medical links upon arrival in the country which became useful in finding their way round and providing accommodation for first few days in a new country:

*There were no infrastructures available in the 60s really to help you, I was very independent any way, there was no network at all that I could access, but we just coped with the situation, when you are faced with the situation, you don’t just back out, you face it (gp5b.)*

The interviewees placed emphasis on being independent, which was a theme present in the majority of the interviews, implying that they did not wish to ask others for information or other support, some reported proudly how they had not taken family’s wishes and feelings about migrating to the UK because they preferred to be independent. Their confidence may be owed to their entrepreneurial thinking and the professional training they had received.

The doctors were less likely to seek support from friends, especially from friends/colleagues originating from the same city and country. They preferred to be independent and stated that in years to come they did not want reminding that they had been successful because of someone’s favours; additionally, they did not want news travelling back to their home towns about their struggles. In part this may also be a reaction against a system where personal contacts seemed too important a factor in success. Reacting against this system, it perhaps became important for these doctors to succeed through merit, not social contacts. The following quotes illustrate how doctors gave preference to institutional links:

*Yeah, we few had friends as well, yeah but they were not known straight away but you make your own place and then actually you meet people, you find out people, we did not know anybody before coming. I would not have relied on*
friends in any case because I did not want them to tell me after 10 years that I was only able to navigate my way round because of their help. I preferred institutional help in the first instance (gp3s).

I had been in touch with GMC before coming here and they offered me a clinical attachment for four weeks, so I came. I did not seek help from friends because it’s better to receive help from institutions, you don’t have to pay back favours for ever to them. They [friends] also remind you from time to time, I was the one who brought you here, remember etc. (gp4s).

While some doctors acknowledged the significance of support from their networks in the initial period of settling in, they also talked about the implications of such social relationships that arose from a shared ethnic community:

Our community is very tight knit and news of any failure travels fast and even before you know, it reaches your home town and gossip starts. Also, we were going for same jobs and you did not want to lower your own chances of securing a position by helping your comrade. That’s not to say that I have not helped anyone or that no one has helped me, but I think networking is based on a criteria and what that means is that you don’t just help anyone from your city or place, you have to be cautious. I have helped friends who were my friends from college comradeship or who have been family friends for a long time and whom I trust (gp7b).

The above quote highlights the significance of the trust required for networking and the complexity involved when a community is close-nit, with individuals competing with each other, along with the unconscious rules of individuals’ social backgrounds determining the strength of these networks. The majority of interviewees with both Indian and Pakistani origin described networking across beneficial:

I [Pakistani origin] found Indian doctors very supportive in work related issues; they gave me detailed information about what to expect in interviews, selection processes, which consultants to avoid, but my own [Pakistani] were trying to avoid me so that I couldn’t reach out to them, they did not tell me a single thing. I have heard them often bitching about others from their own cities and saying things like, look at so and so, he is trying to act bigger than
his boots, his mother was only a primary school teacher or that his father was only a coolie. That’s why, I did not associate with doctors from my own city and country. I would rather seek help from an Indian doctor because there is no such threat in that relationship. They won’t let your home town know if you failed an exam or did not get a job in your specialty etc. My Indian friend told me the same; he said the person who helped him most was a Pakistani doctor (gp4s).

The above quote shows how conscious the interviewee appeared to be about social status, not wishing to take any risk that may damage his reputation. The above also suggests another motive for doctors to migrate, which is to get away from the class/caste judgments still so prevalent in the homeland, and their desire to acquire social status by profession rather than ‘hereditary privilege’ as previously discussed. Most doctors were determined to use their own agency in navigating the system and not contact their friends and colleagues for support:

_I knew Dr X from before coming here. I met him when he had just got the job in the same hospital as me here in the UK. When we met, he took me to one corner and said, no one here must know that we know each other because they will assume that you helped me to get here. He thought that this will give people a bad impression of him and that he had it easy and they will doubt his own capability (gp6s)._ 

The above account shows that networking was considered in a negative way. This may be related to the interviewee’s perception that he should be selected on merit rather than through networks. Many interviewees said that they left the country of origin because the system was flawed and unless you could ‘approach’ the right personnel, chances of success were slim. They rejected networks because a meritocratic system was important to them; however their views appeared to be based on rather an idealised meritocracy and an assumption that the elites in Britain could achieve their position on the basis of ability and achievement.
It is often assumed that established migrants help out new migrants in terms of settlement. However, the interviewees’ accounts show the complexity involved in networking and although a desire to escape ascribed status is one motive for migration, a desire to generate status in the homeland is also another. There was also a general consensus that friends/coworkers expected each other to find their own feet:

_I think it's because they think that it did not come by easy to us, so why should we help someone else, they should also be thrown about like we were (gp3s)._

The following doctor stated how his friends avoided contact with him in the work setting as they did not want to be stereotyped by others:

_They [friends] did not want to be known as Mirpuris [Kashmiri region in Pakistan] because others make fun of you that you are from a backward area (gp4s)._

The above and other quotes show that while there was some level of mutual support among the interviewees, there were also prejudiced perceptions of each other. Apart from cultural reasons, this form of behaviour may be reflective of the racism experienced by overseas-trained South Asian doctors who in turn project such feelings on to others who they think are lower than themselves (Husband, 1982). Linblad (1993, 125) also echoes the above regarding her experiences in the UK and associates such behaviour with how racism impacts on individuals:

_Having been looked down by the British made me enjoy looking down on others myself._

All four female doctors in the study had had their husbands (doctors) either accompany them or arrived earlier. They can therefore be regarded as chain migrants, who had networked into existing networks. As explained previously, the female interviewees entered in to already networked communities. There were also examples of family migration where husband and wife both entered the UK at the same time, which differs
from the usual pattern of young, male migration. It also shows that temporary highly-skilled permit holders were allowed family migration and exempted from immigration restriction when other immigrants from South Asian countries were not exempted (Kofman, 2004). The post migration networks formulated by the doctors in their respective settlement communities will be explored in Chapter 7.

5.5 Meso-Structures

Intermediate ‘meso-structures’ play an important role in facilitating migration. Individuals, groups and institutions take on the role of mediators between migrants and institutions which leads to the emergence of a migration industry. These mediators can be recruitment organisations, lawyers, agents and other intermediaries (Castles and Miller, 2003).

Evidence from the interviewees’ accounts suggests that the migration industry was also in operation in their era, and there were local recruiters who were in an advantageous position to facilitate migration. The interviewees mentioned vouchers being distributed and work permit scheme also being in operation. As explained earlier, the voucher scheme in operation in the early 1960s encouraged migrants to accept invitations to migrate. The following account shows that there was an exchange of favours, rather than the brokers charging high fees, which may have been reflective of the higher social status of the doctors and their ability to access influential networks:

One of the managers from the local job centre had an appendicitis operation which I performed. After the operation, he came up to me and said doctor sahib, we have those vouchers for the UK, if you are interested. By this time, I was already working after my qualifying, he said, come to me and I will give you the voucher, there were three of us, a professor of ophthalmology a colleague who was a house surgeon, and another boy who I forgot to mention, we all went (gp5m).
The interviewees’ accounts showed that there was a large network of people working in the migration industry and working with various governmental officials in both the receiving and sending countries. The account of the following interviewee, who came to the UK in 1964, shows a pattern of ‘aggressive recruitment’ activities mediated through extensive networks and the use of the vouchers scheme:

I was offered a voucher by the labour ministry at the time. I had no passport, no intention to come. I was well off, father was a businessman. My uncle was also very influential in the city. One of the travel agents my uncle knew, he was an international traveller, he said you must go there even for six months; they will treat you like a hot cake he said they (UK) will receive you with overenthusiastically, because they desperately needed us doctors, and there was a shortage of labour force but there was a shortage of doctors too. Anyway, I started thinking about what this man had said, I think he had sown the seeds. But I had no passport and it used to take two years to get one unless you used bribes which neither I nor my father liked to do. The agent said, I will deal with all of that, you just get ready, within two weeks (gp2s).

The period referred in the above account closely ties in with the period referred by Gish (1971) who argue that the immigration Acts of the 1960s and 1970s were intentionally designed to favour Commonwealth doctors over their less skilled counterparts, and that 40% of all vouchers issued between 1966-1968 to New Commonwealth and Pakistani origin professionals were allocated to doctors. The above account suggests that this practice was being implemented even earlier than the period referred to by Gish.

Migration in general is perceived as a process in which migrants are active actors who employ their own agency in making the decision to migrate. This was not the case for the following interviewee who talked about being plucked out from the country of origin for his skills and experiences:

I got an offer to come to Edinburgh through a WHO scholarship, because one of the professors from Edinburgh went to look for the brightest medical
students, so, he made an offer to me and asked if I would like to come to UK, I said, ok. So, I grabbed the opportunity. He came..., he made observations of my work for a few weeks, my professor was very good as well, after observations I was offered the scholarship and invited to work in Edinburgh in 1966. Although it was a scholarship, they changed my job to house officer and then senior house officer after a while (gp6s).

The above account reflects the labour shortages and informality of the systems that operated at the time with no explicit criteria for recruitment or considerations for equal opportunities. The interviewees’ accounts also confirm that migratory movement becomes a self-sustaining social process once it has started (Castles and Miller, 2003). For example, the migrants might find partners in the new country, which three of the interviewees did. Migrants who find living and working conditions better than their own country of origin may re-migrate. In two of the cases, this was the case as illustrated by the following account where the interviewee describes how he was summoned back after returning to India adhering to the original plan of settling back, as the following accounts indicate:

It was a rural area and there were only five to six other Asian doctors in the whole of the area (UK). I said to myself; let’s go back now, so I went back to India. I had only worked for about two months in a hospital when one day I received a phone call from the consultant in Kettering hospital inviting me back to work for him, he said, please come back; we need you and we have a job for you. I discussed with my wife this job proposal. I said to her that there is ongoing politics in India, in order to survive here, you have to know so many important officials for little things to be done, if you don’t know anyone, you stand at the bottom of the queue. On the other hand, these people from UK are inviting me to come and work for them, what more do I want? She said, ok, you go first and then I will come, so she joined, me later after eight months (gp1m).

The above also highlights how family, especially spouses, were closely involved in the migration decision as discussed previously. It also shows the importance of social networks in the UK in encouraging re-migration and how access to information/job offers
could tempt doctors back again.

I will now turn to the post migration experiences of the interviewees. The following section will explore the immediate experiences of the migrants following their arrival in the UK, along with a discussion of how the medical system was navigated by the interviewees.

5.6 Experiences on Arrival in the UK

Unlike their unskilled counterparts, the majority of interviewees’ accounts show that special entry privileges were granted to them. The interviewees’ pre-conceived positive attitudes about Britain were reinforced from the point of entry by such experiences:

\[
\text{When I arrived in the country, an Englishman came and met me at the airport. He had been sent by the hospital to pick me up. He took care of my suitcase immediately. I was so impressed, I wrote a letter to my wife the same day and I remember to this day that I wrote to her that I was in heaven on earth (gp8s).}
\]

The interviewees’ accounts showed that their experiences sharply contrast with those of lay South Asian migrants. For example, in 1979, an Indian woman was subjected to a ‘virginity test’ on her arrival at the Heathrow airport, it was alleged, that this was undertaken to ascertain that she was the ‘bona fide virgin or fiancée’ of the man who had sponsored her.\(^{10}\) Similarly Asian children were being X-rayed upon arrival to the UK to determine their ages and whether they were dependent children of the sponsor (Husband, 1982).

\(^{10}\) Virginity tests for immigrants ‘reflected Dark Age prejudices' of 1970s Britain
8 May 2011, The Guardian
http://www.guardian.co.uk/uk/2011/may/08/virginity-tests-immigrants-prejudices-britain
5.7 Navigating the UK Medical System upon Arrival

A most common experience among interviewees upon arrival to the UK was that of working at several temporary locum jobs, ranging between 3-6 months and then one year afterwards, although, in some situations it lasted only a few weeks. Specialties considered less prestigious were cited as their most common places of work:

*With some specialties it was very easy, like orthopedics, psychiatry, there was a divide from all, even geriatric medicine, because of local people were not interested in doing those types of jobs, but these are jobs which we filled up, Geriatrics, psychiatry, casualty, orthopedics and then to get a general surgery, general medicine, pediatrics, it used to be very hard (gpm7).*

Since being in employment was crucial because it provided accommodation and extension of a visa as well a salary, the interviewees stated they were left with no alternative than to accept any job that became available:

*First initially for 6 months I did 10 weeks locum, then I went in to do another locum for 2 weeks, see what used to happen, with job you used to get a room, if it is a resident on-call, yes, resident on-call, then you always used to have a roof on your head, if you have got a poor job, you don’t have a roof (gp7m).*

For many, lack of family support was an added dimension:

*I had no relations, we had no family member here whom I could rely on and therefore you had to get any job, whatever comes your way (gp1s).*

As many interviewees talked about being approached by consultants for temporary jobs via their friends, this would suggest that their vulnerability was exploited by NHS employers who needed persons to take on a post.

Following The Merrison Report (1975) which highlighted the competence issues of overseas doctors, as explained in the literature review, interviewees who came to the UK after 1975 had to undertake a Temporary Registration Assessment Board (TRAB) test. This was a new system introduced by the GMC for the purpose of evaluating the
professional and linguistic ability of a physician who was trained outside the UK, and covered knowledge of both English and medicine (Douglas, 2000). The test only applied to those doctors who had not qualified from a medical college which had reciprocal arrangements with the UK. In one case, where a respondent’s wife had been given full registration prior to entry into the country, she was asked to take the PLAB\textsuperscript{11} exam before she could be granted full registration upon her entry into the country, as the test had since been introduced.

The interviewee talks about the informality of the recruitment process, with a consultant offering a job without any formal application. Interestingly, the doctors previously talked about obtaining jobs on merit rather than from knowing someone, however, they stated with pride that they had been selected, as the following account states:

\textit{\ldots then I got a locum job in Gloucester, that consultant there, he liked me, he said okay there’s a regular job coming, in September you can have that (gp2b).}

Several of the interviewees recalled being headhunted for their expertise which would suggest that overseas-trained South Asian doctors were vulnerable and being exploited:

\textit{We worked hard, and previously, many times in peripheral and district general hospitals, they always used to prefer experienced people because we had done most of the jobs in India, technically we are alright, our hands are okay (gpm7)}

Another interviewee’s account suggests vulnerability, unequal power relations and exploitation:

\textit{It is because, when you are thrown into the deep end we don’t have any cosy life, we don’t have protection, and we are in different environment and you can’t go and stay anywhere and, you have to get… beggar has got no choice, you have to take a job, whatever job comes your way (gpm1).}

\textsuperscript{11} TRAB was later renamed the Professional and Linguistic Assessment Board (PLAB)
The metaphor of the beggar was used by a couple of other interviewees, which is ironic in that the majority of the doctors in the study did come from very privileged backgrounds. Perceptions of their professional downgrading is likely to be reflective of the particular culture of the NHS operating at the time, and its potential impact on people especially when the political activism by the South Asian medical associations was not in existence at the time.

In general, the interviewees’ accounts lend support to the findings of earlier studies such as Doyal et al. (1980, 54) who stated that overseas-trained doctors provided cheap labour:

...the traditional justification for the above situation offered is that it constitutes a form of British ‘aid’ to the third world, training health workers who then go back to their own countries. However, a closer examination reveals that in reality these workers provide a crucial source of cheap labour and their utilisation has always been an important component both in keeping down the costs and in rationalising the labour process in health care.

5.8 Reasons for Not Returning

The doctors in the study were a group of professionals who were motivated to return to relatively privileged lives on the Indian subcontinent once they had gained a qualification here. Hence, an understanding of why that did not materialise for many is quite important. However, since a full discussion is outside the scope of this study, a brief summary is provided in this section.

Almost all the interviewees stated that as the length of stay increased, family formation took place, the birth of children required stability in life. The UK system offered new kinds of opportunities than initially envisaged such as the new niches carved out in the General Practice industry. Personal and professional relationships built over the years were mentioned by all those interviewed, while such networks were weakening in the countries of origin. Though poor working conditions in the UK were described, comparisons were
drawn with conditions in the countries of origin and preferences were stated over practice style in the UK which offered them autonomous positions and social status. The UK was also preferred as it offered enhanced education and career opportunities for their children, the many of whom also went into medicine as a career. In one case, a child’s specific disability needs being better met within the context of the UK was also mentioned. Attachments with places/people/communities that they worked with were also cited as common reasons to stay on, whereas lack of improvement in social/economic/political situations in the country of origin cropped up in many accounts as an ongoing push factor. The interviewees’ experiences in this respect are quite similar to other less privileged groups of migrants who also often intend to return, however, due to growing ties with the new country, their return becomes a myth (Castles and Miller, 2003).

5.9 Summary

This chapter has discussed the empirical evidence that relates to research question four of this study, asking how the migration experiences of overseas-trained south Asian doctors relate to existing theories of migration. The findings show the nuances and complexities of the migratory process and the intertwining of macro-, meso- and micro-structures, making it difficult to highlight one single cause for migration. The interviewee’s accounts reveal the significance of the micro-level role of religion and spirituality in the dynamic process of international migration, which has not been explored previously. The role of the family in the migration decision was only significant for a quarter of the doctors in this study. The macro-structures facilitating migratory movement included provision of structural support in the form of exemption from strict immigration controls. The availability of opportunities in Britain such as vouchers, work permits and clinical attachments acted as catalysts and mechanisms for promoting the migratory process. These methods of enabling doctors to migrate appear to be a combination of active and subtle recruitment drive on the part of the NHS.
While the primary purpose of migration was stated as being the obtaining of a postgraduate qualification, the interviewees’ accounts testify that beneath the surface lie much more complex and deep-seated issues, that appear to relate to the legacy of colonialism and its impact on people. At first glance, the typology of these highly-skilled migrants may appear to fit with what Iredale (2001) describes as ‘Government induced’ or ‘industry led’ as there is evidence of active recruitment by the government and the NHS; however, the subtle reasons behind this such as a fascination with Britain, its culture, its perceived superiority in medical training and education facilities, including advanced equipment, and how British degrees and experiences are held in high esteem in the countries of origin, all associated with improving a migrant’s status, can be seen to figure strongly in the migrants’ accounts; they provide evidence for the dependency and opportunities created by the colonial legacy on a personal, emotional and institutional level. In light of the findings of this research study so far, I argue that the migration of overseas-trained doctors is a social phenomenon that has been colonially induced through the educational and social processes that were part of the colonial rule at the time, and continue to play a role in conditioning individuals’, communities’ and nations’ way of thinking.

In relation to social networks, the key networks described are institutional rather than based on kinship. The findings show that, so far, Migration Network Theory has not incorporated the cultural issues that rendered some networks as obstructive/ facilitative for this elite group of migrants.

In the following chapter, I will discuss how migration transformed into settlement and how the overseas-trained South Asian doctors settled into their respective roles in the community.
Chapter 6: From Migration to Settlement and General Practice

6.1 Introduction

This chapter is concerned with the impact of the migration of overseas-trained South Asian doctors on UK society, how they rebuilt their lives in Britain and integrated in the NHS and their respective communities. In the previous chapter, I explored the migration processes and how the doctors in the study navigated their way into the UK system and the barriers that they encountered in integrating fully into the institution of NHS. This chapter builds on their subsequent experiences. The empirical evidence relates to research question 2 that asked what perceptions doctors in the study had of their mobility in the NHS in terms of working conditions, career development and of their contributions. It also covers evidence in relation part of research question 4 that asked what insights the ‘lived experiences’ of highly-skilled labour migrants can add to our understanding of community cohesion and how their experiences relate to social capital, entrepreneurship.

This chapter examines the empirical evidence related to the entrepreneurial process that the doctors undertook as a reaction against racism which was experienced in the form of blocked social mobility, in order to integrate into the institution and the communities that they served (Auster and Aldrich, 1984, 46). I consider this new interpretation of their contributions in the context of entrepreneurship in this chapter.

I believe that the concept of entrepreneurship provides a useful analytical framework for the investigation of the GP’s contribution and community activities. Traditionally this concept has been discussed in relation to the lesser skilled sectors of the labour market. However, Raghuram et al. (2010) endeavoured to expand its analytical use to the skilled sector in their research with geriatricians of South Asian origin in the UK and found clustering of South Asian doctors in geriatrics which is a marginalised area of medicine
and has relatively high proportion of South Asian doctors. The empirical results of this study build on the work of Raghuram et al. (2010).

The empirical evidence will be examined for the nature of their contribution as health professionals in the rural and inner city case study areas and will identify the factors that determined why and how the entrepreneurial activity was generated as well as discuss the process of entrepreneurship.

**6.2 Understanding Entrepreneurship and General Practice**

Existing theories on entrepreneurship have sought to explain the causes and consequences of entrepreneurship and agree that it is the interactive effects of structural factors (at a societal level), and group and/or individual level characteristics that underpin the phenomenon, while how they interact with each other determines groups’ propensity to succeed (Zhou, 2004). Experiences of exclusion and discrimination that account for structural factors at societal levels have been discussed in previous chapters.

In this section, I will discuss how the doctors negotiated entry into General Practice, and the interaction of structural factors, group and/or individual level characteristics, that facilitated entrepreneurship. I begin by examining the push/pull factors for entry into General Practice followed by a discussion as to how the doctors in the study negotiated this entry.

**6.2.1 The Push and Pull Factors for Entry into General Practice**

Entrepreneurial motivations are often defined as fitting into ‘push’ or ‘pull’ factors (Kirkwood, 2009, 346). The doctors in this study described the push factors for entry into General Practice as: harsh working conditions, mostly working as junior doctors despite having several years of experience under their belt in the country of origin, frequently moving to temporary jobs in high demand areas, and being pigeon-holed in the least
desired specialties. Most of them stated that they were stagnating in jobs that did not relate to their career progression and there was no career path planned. However, a few stated that, they had progressed to the post of a registrar, although they knew that they were going to be held back at some stage, as they had seen it happening so frequently with their friends /colleagues. Many were unable to pass part of the postgraduate qualification exams partly as their clinical experiences did not relate to the desired qualification. Return home was not an option, since being engulfed in the migratory process (See section 5.8 Reasons for Not Returning), for many the only viable option was that of General Practice. The role of institutional racism in the NHS was acknowledged by several of the doctors in the study:

*The bad thing here is that if you were competing with a local doctor, no matter how good you were, the English or the Scottish will always get the job. There is discrimination, and the thing is you could not even complain about it as it would be noted and then it will follow you wherever you go for the job and then you will have difficulty* (gp3b).

The above quote suggests that the interviewees were well aware of widespread discrimination and victimisation, but felt unable to complain as a result of the existence of power inequalities and the likely implications for them if they were to speak up against powerful people. This can be evidenced in the account below:

*One of my friends decided to take it all the way to GMC to defend his case and won, there they asked him the question that it appears in the court that this is a case of racism, do you want to pursue it further, he said, look I am living in a sea, I don’t want to be enemy with crocodiles.(laughs). He said I have got a few more years to go; I want to live peacefully with the crocodiles (gp9s).*

The above findings affirm Collins’s (2001) findings in a study undertaken to address the implementation of *Tackling Racial Harassment in the NHS, A Plan for Action (1998)* in which he concluded that the fear of victimisation was a significant factor in the non-reporting of numerous racial harassment cases (Collins, 2001).
In nearly all cases, the doctors showed hesitation to use terminology such as *white*, or *black*, instead frequently using terms such as *locals* to describe white or English and *our own* (apney log) to refer to patients or others from the same race/culture. Reasons as to why the doctors hesitated to describe people in racial terms are discussed Chapter 7.

Reference to *our own*, however, may be an acknowledgement of the researcher’s identity, reflecting the greater openness that results from a shared ethnic and immigrant background.

Careers advice being given by white consultants was also strongly pointing them in that direction. In nearly all cases, the interviewees talked about being advised by their consultants to go into General Practice:

...he [consultant] said why you don’t do General Practice, you would settle better and your family will be settled as well (gp3b).

This experience was common among other interviewees. Their consultants were directing them to go into the discipline of General Practice rather than continue pursuing the consultant route. The interviewees held the consultants in high esteem and generally viewed their advice in a positive way, except in the following account, which sheds some doubt on the advice being authentic:

No idea, why they [consultants] were doing it but I think probably they didn’t want Asian or outsiders to go in consultancy... (gp1b).

The above quote raises a number of issues. Firstly, Gish’s (1971, 52) assertion that... the National Health Service simply could not function without overseas doctors’ suggests that it would have been in the consultants’ own best interests to have sufficient competent junior doctors at hand to run the hospital service effectively; this heavy reliance will have necessitated the forming of a good working relationship. This is not to deny that some genuine working relationships would have been built among individuals, however,
overwhelming evidence lends support for the assertion of Navarro (1978) that class and race Collins (2001) are factors that have been used to oppress doctors from lower class and ethnic minority backgrounds by consultants who are pre-dominantly drawn from the white upper middle classes. The interviewee’s accounts also support Samers’s (2010, 126) assertion who draws our attention to the limitation of Human Capital Theory, which only acknowledges individuals’ skills, educational qualifications, and abilities and does not take account of other intersecting characteristics such as race and gender.

6.3 Negotiating Entry into General Practice

The interviewees talked about how their own social networking provided instant word of mouth information about opportunities and know-how, and also offered personal support:

... because my friend used to work next door here... and Dr A was a friend, we used to meet in meetings, then he said err because their practice is a training practice and they wanted to take a trainee but that trainee he decided not to come here, then my friend told me there is a vacancy, why don’t you go and give your application (gpm7).

Ellis et al. (2007) argue that spatial accessibility of jobs may well be just as significant as social access to jobs. The majority of the interviewees stated that there was a also a glass ceiling in General Practice jobs in well sought out practices which would be offered to ‘local lads’ (white British) first whereas the overseas-trained South Asian doctors would only be successful if there was no competition:

I went for an interview, there were a few of us, all Asian, waiting outside, they [the interviewing panel] told us that neither of us had got the job but they had one more interview to do next week because this doctor could not make it that day. We all knew it would be a local lad for whom they were not only prepared to wait but also, he was the one to be appointed. Our fear was confirmed later when we asked around (gp9s).
Although the interviewees in general were reluctant to explicitly admit discrimination, comments like the above are a fairly strong indication about their perceptions of it. The interviewees had varied experiences in finding jobs, some were able to find work with relative ease, while others described an element of gate-keeping in General Practice, carried out by both white and other overseas-trained doctors:

When I was looking for jobs in general practice, it was proving to be very difficult. People used to say, yes you are a good doctor and make promises that we will give you partnership but when the time came they [Asian doctors] did not stick to their words. The thing with white GPs was that they would also make promises that we will contact you when we have a vacancy but they would actually appoint their own. With our doctors, they did not appoint anyone because there were no rules at that time that you should have so many patients, they were just gate keeping (gp1m).

Waldinger et al. (1990) refer to opportunity structure which is seen to consist of market conditions that immigrants exploit, for example, ethnic consumer products. The following account affirms the above as he explains how he was invited to apply for a job in a practice area where South Asian migrants were settling in. It appears from his account that alongside his bicultural literacy (acquired by being trained in an ex-colonial country, and several years of experience in the UK), other personal factors such as being married to an English woman, were considered as additional positive features:

This time round, I did not bother applying but I got a phone call from one of the doctors on the panel asking why I had not applied. I said there was no point because I knew I was not going to get it. He told me to come for the interview and bring my application with me which I reluctantly filled in but I wrote very little on it, I just said please see previous application etc. I went for the interview, the doctor who rang me said, we have all met you but Mr so and so have not seen you, Mrs so and so have not seen you, therefore only they will be asking you the questions. One of them asked, are you married, I said yes,
and they said, you are married to an English girl, I said yes, they said, in that case you are going to stay in this country(gp9s).

The interviewee's accounts suggests that through repeated negative experiences, he had lost faith in the fairness of the system, however, the informal networks that he had made worked in his favour and was head hunted. It also appears from his account that his migrant status was mediated by his marriage with an English wife which was perceived as a marker for permanence in the country offering stability to the employer.

Social and demographic changes and proximity of residence create a demand for ethnic services (Ladbury, 1984, 107). The following interviewee talks about the dynamics of the opportunity structure and how employment niches were being created in this area:

In Sheffield at that time 85% of people from South Asian backgrounds were Mirpuris and there were few Asian, nearly all of these were uneducated and were working in factories. They were just starting their businesses and few went into restaurants and cafes. At that time, even their children didn’t speak English because they had just arrived, I am talking about in the early 60s. I was offered the job because it was becoming increasingly difficult for locals to manage the language and culture issues(gp9s).

As some communities and areas in the UK were becoming more diverse, the demands placed on the inner city practices were growing, and it appears that overseas-trained South Asian were being purposely sought out. Some of the interviewees talked about being recruited by white senior practitioners through previous links, which suggests that since they were known quantities, they were likely to be considered safe individuals from the employer’s point of view. Apart from niches being created in areas of high ethnic density, the interviewees also talked about opportunities that had been created by the flight of UK qualified doctors from white working class areas:

Yes someone was working there before, a white doctor; he moved to Spain, the practice was very deprived, debilitated. He was doing that Spanish practice for almost over a year, neglecting this all together, so it was really neglected, yes
living in two places, hardly any... there wasn’t even a list, only four or five patients. I did a lot you see, that practice you see was in one of those terraced houses and hardly anything there, so then I think within three years more or less I built up a beautiful purpose built practice in the area, and then it was like jungle mein mungal.  

The result was in a few years time I got the GP of the Year Award. (gpm4).

The above account shows how, with determination and the use of his entrepreneurial skills, the interviewee was able to transform a deserted place into something special, even outstanding. Other interviewees talked about utilising structure and agency for the transformations they undertook, which can be evidenced by the following:

...system is pretty good here, they call them cost rent scheme that is when you buy... you take a loan from the bank and that health authority has to pay the interest (gpm4).

For some of the interviewees, networking with other overseas-trained migrant doctors provided vital links, especially those who were now reaching retirement. The following interviewee’s account shows that he was appreciated for his attitude to work:

I was offered a couple of other jobs which I didn’t take, one was in Rotherham, they were offering me £11,000 and all the seven were white and senior to me. Another one was similar. I took this one because it offered £14,000 and also, it was run by a Polish doctor who was about to retire. It was my good luck that I bumped into a local doctor in a meeting after completing my training, I did some local jobs for him, he was a Polish GP, and he asked me what I was doing my training, told him I was working in X hospital. He said I was hard working and asked me when I was going to finish that job. He said come and work for me, so he took me as a partner, he was soon reaching 73-75 years of age, and on his retirement, he handed over the practice to me (gp8b).

This was echoed also by the following interviewee where another migrant doctor was possibly impressed with his hard work or values:

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12 An Urdu language expression meaning transforming of a place from dry woodland into wonderland.
I accidently met an Irish GP who was very influential; I did some weeks work with him as a locum. He for some reason wished that I inherit his practice. I accepted his offer. I found out from the practice history that there had never been a local doctor in that practice, it was built in 1903, they had had an Irish-Irish-Scottish-Polish-Indian doctor since it was built. After five weeks, he had a massive heart attack and he was no longer able to work…. He talked to the chief executive of the PCT and wrote to Secretary of State in Health and Social Care. They both said you can go ahead with your plans. He phoned me and said it is good news… I worked there for 27 years (gp2s).

The above accounts suggest that the niches previously carved out by the earlier overseas-trained migrants such as the Irish and Poles were now claimed by this new group, the overseas-trained South Asians. Logan et al. (1979) point to the existence of an established pattern of dependency on migrant doctors by the North East Thames Regional Health Authority prior to the arrival of South Asian GPs. Cargill (1969) notes a disproportionate number of Irish GPs working in Birmingham and Essex. The interviewees’ accounts suggest that the migrant status created a sense of bounded solidarity and also facilitated networking.

6.4 Entrepreneurial Activity and Innovation

The concept of social embeddedness is significant to entrepreneurship and it has been argued that entrepreneurship must involve and draw on society if it is embedded in the social context (Jack and Anderson, 2002). The interviewees in this study believed that they were providing something which they considered the local community needed and would be beneficial; but equally they drew upon the locale to support their business in each of the three case study areas. Their accounts show that viability was produced in ways that involved social factors and embeddedness and the GP practices were embedded in the locale, in other words, while the interviewees drew value from the local structure, they simultaneously added value to the structure. The interviewees talked about local structures
in the form of context, the local environment, and becoming part of the social fabric of the society, for example attending a wedding party in a Working Men’s Club and other local cultural and religious events. A detailed discussion of social embeddedness is incorporated in Chapter 7 of this thesis. The interviewees attributed local factors to their success. In the ethnically dense areas, this occurred in the form of locals providing inspiration for the venture. For example, one interviewee was invited to apply for a job by the local NHS, and also patients from the same race and cultural background, were willing to help with the opening of an additional practice, for which the doctors in the study acted as socio-cultural mediators, providing a culturally and linguistically competent service.

In rural areas, the interviewees talked about ways of embedding (at both a social and professional level), for example, through the membership of rotary clubs and golf clubs as well as other embedding actions including involvement in fundraising shows in the local area. Together with other innovative activities instigated by their practices, this projects an image of the doctors in the study as individuals who were genuinely interested in the wellbeing of local communities. The scarcity of resources in the rural environments went hand in hand with the entrepreneurial spirit of the interviewees and such contexts provided them with perfect places in which to grow.

Entrepreneurship and innovation are interlinked. Determination to improve services for the most needy was stated as the main reason for innovation by many of the interviewees. Many of the overseas-trained South Asian doctors talked about their frustrations as to how they were unable to implement their vision in the country of origin as a result of financial and governmental constraints. Many in the study had a clear idea as to what an excellent healthcare model should look like, as they had several years of experience in the country of origin working in remote villages with very few resources, as well as in the UK. The experiences in the origin country may have informed a different perspective on healthcare
provision and use of resources as well as the experience of migration that may have encouraged risk taking and innovation.

Community ties and networks were mentioned as playing a vital role in the start-up process by many of the interviewees:

... I had to set up from scratch, I came from a hospital background, I didn’t need to even buy a spoon, but when I came here, even the glass of water that I needed to drink, I had to buy. Pakistani community helped me greatly. I got to know some shopkeepers, Asian grocers from whom I used to buy my groceries. When I was looking for a place to rent for my second surgery, they used their networks and got me some premises on a very low rent, £5 per month I think it was. I had patients but no premises. I had to be able to deliver services in a short span of time. With the community’s help and word of mouth, I got both the premises and the patients (gp9s).

The following interviewee talks about continually searching for creative opportunities after some negative experiences of working with other overseas-trained south Asian doctors:

I talked to Dr K about my problems, he had similar experiences, he was sympathetic, he said there is a room available upstairs to my practice, he said go and start practising. So, I had a telephone line connected, brought a table and chair and started to practice from there (gpm7).

He talks about how he gradually built the patient list vital to the survival of his business, and then expanded:

Slowly, I built up my patient list. When I used to see my patients from the old practice, they used to ask, oh, doctor, where have you gone, they are telling us you have left the area, we miss you etc. I told them about the practice, then they started joining my practice, one came, another came and with six months I had around 500 patients. The patients were predominantly locals [white]; they developed a good relationship with me. Then I started looking for premises in a suitable area. I saw three shops, one of them was empty. So, I rented and
converted it into a surgery, and then there was no turning back. Within a year, I had 1000 patients, in the next year I had 2000 patients (gp7m).

His account below shows how he networked with another overseas-trained doctor and continued to aim higher:

After this, Dr K approached me, he said, it will be a good idea if we join up our practices and have a bigger practice, which we did (gp7m).

The interviewees talked about what can be described as entrepreneurial behaviours such as injecting vision, attracting and exciting others and persistency:

We started to design a project in our heads that we should have a larger building which should be modern also. This building that we are in now, it used to be a bank building which had been deserted for a while. After the bank, someone else came but it did not work for them, so they left as well, it was so dead business wise. We both started exploring how we could materialise our ambitious plans (gp7m).

He talked about the structures that acted as lubricators for their business plans. His account provides evidence of positive institutional networks and support:

At that time, there was a very good person working in PCT, he was a chief executive. He said, R., we will support you with your project and do whatever we can do. He said, we need a good surgery in the area. The PCT was extremely helpful; they said you can have a lift installed as well. We were so grateful because we had not thought about that. They said don’t worry about finance; we will help you with that. We raised some money ourselves, me and Dr K and we went to ask for money from the bank. We shared the loan between ourselves and PCT also gave some development funds. Then we developed this project. This building that you see now was just a shell, there was hardly anything inside, everything we had was tailor made, we had to work with architects, builders which was not in our experience before. We asked them to design four, five, consultation rooms, we wanted a spacious patient waiting area, toilets, lift etc. (gp1m).
Individuals and groups can only work with the resources that are made available to them by their environments. Aldrich and Waldinger (1990) state that market conditions shape the structures for opportunity that may favour services to co-ethnics, and areas where the mainstream market is served. Such structures also include the ease with which access is obtained, which is determined by how much inter-ethnic competition there is and the nature of state policies.

As a result of the positive interactions of the above, the above interviewee goes on to state that he has been able to integrate into mainstream institutions and widen his contacts. As a result, his business has not just become an ethnic enclave; rather, it is actively involved with mainstream activities:

*I started to build my contact with other GPs in the area and joined the local medical committee. They represent all the GPs in the area. There was a vacancy for a member and I put forward my name and was selected. I used to attend meetings and meet other doctors in the area. This was a pre-dominantly white area, all the others were white in my area but they accepted me as one of them. I was a member of the committee for three to four years (gp1m).*

The need for proximity to a co-ethnic clientele and ethnic resources has been acknowledged as crucial in the initial stages of development in ethnic businesses as they provide necessary support for survival (Portes and Manning, 1986). It is notable that community ties and networks have also been stated as significant factors in the establishment of self-employment for Jewish people (Goldscheider, 1986). The above account shows that community networks were vital in helping the majority interviewees get established in high ethnic density areas, and this factor may have been important in encouraging Asian doctors to switch to General Practice.

A desire to take risks is a feature of entrepreneurialism. The interviewees’ accounts show that risk management was a key consideration by all of them, and they used their networks effectively as they offered support concerning know-how; however, each particular context
had its own particular issues which meant that there was risk taking involved. The following interviewee talks about the risk involved in setting up a new practice, which was a typical response in this area:

\textit{It was quite a risk taking a job because you don’t know how things were going to map out, whether you will have patients, especially business wise the area was quite run down, you can imagine what it would be like, even the bank had gone somewhere else, because there was no prospect of business in the area. I didn’t know if I was going to have good practice partners etc but I was very committed and wanted to make it work (gp1m).}

The interviewees’ accounts show that their own agency, perseverance and faith contributed significantly towards risk management:

\textit{I didn’t know how the patients were going to react to me, My salary depended on the number of patients so I had to increase the size of the surgery, I was single handed but by the grace of God, I turned it around. When I started my practice, houses were being demolished; a lot of them left me. My practice size was, I can remember the exact number, 2737 after 3 months, I had 1700 patients. I lost more than 1000 patients (gp9s).}

The interviewee’s account shows that he was aware of the uncertainty of how his patients were going to receive him as a doctor, which is likely to be a big challenge for all GPs as patients can choose which practice to register with. Like many other interviewees he was not quick to jump on the bandwagon and name it as racism, rather, he and the others always appeared to do a very thorough assessment of the situation. He believes that there were multiple reasons for these challenges:

\textit{It was partly because I was a new doctor, they had never had an Asian doctor, for generations, they were having English doctors. In my practice, three generations had practiced, grandfather, father and then son from whom I took over, so it was understandable, that people will feel apprehensive, they thought, strange person, strange name, strange everything Asian, to start with, to be very frank, there was some of that as well, okay, so quite a lot of them left me (gp9s).}
He talks about how he was able to gain the trust of his patients and how the number dramatically increased from within the Asian community:

I established the surgery, even though I was Asian, people, in a few years time, started knowing me. I am not boasting about myself but they thought I am not rotten, okay, I am as good as they will get anyway, so they started coming to me and the number of patients started picking up. When I started the practice, around 700 patients were from our own community, when I left 9500. It increased to such an extent that I had to employ two more doctors (gp9s).

The account below shows how he networked with other overseas-trained South Asian doctors at a local and global level in order to run a successful practice:

My good old friend Dr H.. was in Libya, he wanted to come because he had a small boy who was growing older he was about to start school and he did not want to send him to Libya and my friend did not want to leave it late. I said, look, I have a big practice here, why don’t you come and join me. So he joined me after I had been in the practice for four years. It then became so big that we were struggling with two, so by this time, I had developed many networks, I got to know where my other friends had gone, some were in Pontefract, some in Wakefield, some in Manchester. The practice had grown so big that we had to appoint a third one [Asian] (gp9s).

Recruitment and retention was described as an issue in many of the geographical locales that the doctors in the study worked. It appears from their accounts that resource mobilisation was facilitated by the fact that they were able to draw on their connections with an instant supply of co-ethnics. However, the above networking mode would also suggest that the overseas-trained South Asian doctors were almost duplicating the exclusive networking that existed among the white doctors, and which excluded the former. Such exclusionary practice shows runs parallels to the entrepreneurial process that their low-skilled entrepreneurial counterparts adopted in the retail industry in the UK, that is, they relied heavily on family members’ labour. The doctors in the study appeared to rely on other overseas-trained South Asian doctors in the same way. There can be a
number of explanations for this. To begin with, this exclusion was not likely to affect the UK qualified doctors as these very niches had been created by their unwillingness to work in such areas in the first place. Aldrich and Waldinger (1990) argue that ethnic entrepreneurs manipulate family and co-ethnic perseverance and loyalty to their own advantage, but they also incur obligations in doing so. The motivation of the interviewee appears to have been fuelled by the prior trusting relationship that has been built and maintained over the years regardless of physical distance. The following interviewee’s account would suggest that this may have been a survival strategy in a hostile environment:

*When you are forced into a corner, you have to learn these things and you have to do it, otherwise there is no go (gp1m).*

As the interviewees had invested a lot of energy and hard work into their newly acquired positions, trust was likely to be a significant factor in forming new working relationships. Its significance can be evidenced as one interviewee talked about forming transnational networks with his friend in Libya. In her study on the Pakistani community, Werbner (1990) also found that a great deal of trading was based on long term trust and personal reputation which subsequently led to the development of chains of entrepreneurs. Many of the interviewees talked about creating employment opportunities for other overseas-trained South doctors who otherwise may not have had access to social mobility.

Entrepreneurs exploit opportunities and this was evidenced in many of the interviewees’ accounts. Several of the interviewees mentioned the importance of seizing additional opportunities to further their own financial strength and enhance health care provision, along with other supportive structures:

*We became a fund holder*13 *practice which meant that we had to do more things, the more you did the less you had to send patients to hospital, okay. So, we had to expand and the FPC [Family Practitioners Committee] were again*

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13 In the 1990s, the NHS reforms introduced GP fundholding scheme which meant that General Practices received funds annually to purchase designated services on behalf of a specified population. [http://www.civitas.org.uk/nhs/download/Civitas_LiteratureReview_NHS_market_Feb10.pdf](http://www.civitas.org.uk/nhs/download/Civitas_LiteratureReview_NHS_market_Feb10.pdf)
very good, I have no complaints against them or executive council, they came and asked what do you want? I said, give us grant, we have got architect; he will do the drawing, so we can enlarge the surgery. They said ok, you apply and we will give you what is called special type of loan where the FPC paid the interest (gp9s).

He talks about innovative work in the practice:

We modified the practice and moved out to live somewhere else. After that the practice got bigger and bigger, I got to know a lot of people who became good networks. I was asked if I would do some occupational work in a hospital. For eight to nine years, I did this work. We bought all the equipment that was needed for a modern practice, all the changes were done, we had ECG machines, respirometry machines, we had a small theatre in which we could do minor surgery, all these things that I could do, it meant that secondary care services were provided on the door step of the deprived communities, it also saved money by not sending the patients for secondary care (gp9s).

The above account shows how structure and agency of the doctors in the study created positive outcomes and how the interviewees utilised networks to secure resources for areas that may not have been able to secure them previously. Reasons for innovation were stated by many interviewees as self-fulfillment, opportunity for broader skill utilisation, enthusiasm for greater autonomy and being able to pursue own ideas. The following interviewee explains how being an entrepreneur became the way to realise his potential and others like him:

We [Asian] were very enthusiastic because this [GP job] gave you livelihood, not just increased income, also we had the skill, because a lot of us had worked long ....time in hospitals, we were over skilled for just writing down a prescription. You know they are boys who have done MRCPs and FRCS, who have a lot of things, I myself, I think I have done with my own hands 200 appendectomies in the hospital and about 150 hernia operations, all these minor operations, they were on my list of things in hospital, I used to do them all. My chief did not even know that patients came in with appendicitis and had
it out and gone home. I was capable of doing small bits and bobs instead of sending them to hospital (gp9s).

The following interviewee like many others explained that the transformations they envisioned in general practice was as a result of making the best use of their capabilities (which were greater than is typical for UK qualified GPs) and resources while offering enhanced primary care services and saving the establishment money:

*We came here not to become GPs, we came to become specialists, we had enthusiasm and we had capability. I did around 300 vasectomies on my table (practice. I did fair amount of circumcision of Pakistani babies, probably 150, ok in addition, I was the first doctor who started doing vasectomy under local anesthetic. It’s because I was able to do it. We made a huge contribution in that sense. It’s only purely because of God’s grace, out of those 300, there was no bleeding, no infection, nothing. Others started following me and they were incidentally most of them all Asians, otherwise it was the consultants (gp9s).*

Using their own agency to improve the provision of healthcare and their own working conditions cropped up in almost every interviewee’s account. The account below refers to all of the four GPs as Asians and comments on the *drive in us* which might explain why the doctors in the study recruited other doctors of a similar background. They were a self-selected group of people, who had taken on the challenge of migration to bring about changes in their personal and professional lives:

*I had a purpose built building just before I left, it was a joint initiative, me and my practice partners, the other building was old now, all of the four were Asian by now. We had this drive in us, all of us, were all determined that our practice should be better and bigger and patients should have access to better facilities, e.g. there should be an operating theatre, computerised system, bigger consultation rooms etc. You see here, we felt that we could have access to funds and resources, we could have our dreams come true, we wanted to provide seamless health care to patients, whereas in India, we had limited resources. We wanted to improve working conditions for us as well. You will*
have heard about the PFI [private financial initiative] government scheme. Most of the practices made use of this initiative (gp6b).

The interviewees talked about having a long term vision and the need to survive over time, up-skilling in areas where they lacked the experience and skill to meet the needs of all members of society:

*I was so much determined to learn that I appointed a locum for two months to do gynaecology and obstetrics, okay, and so many deliveries, I wanted to be capable of doing things, half of the patients were women and if I knew how to help them, wherever I felt I needed to upskill myself, I attended every single course (gp9s).*

### 6.5 Individual and Group Level Characteristics

This section will examine the empirical evidence related to the individual-level/ group-level characteristics of the doctors in the study. The individual level characteristics are described as imported individual traits and behaviour such as age, education, job skills, experiences in the countries of origin and in the receiving countries (Zhou, 2004). The doctors in this study were a self-selected group of highly-skilled people who were fairly young and enthusiastic about enhancing their social status and careers. Many interviewees talked about the postgraduate qualifications that they had managed to obtain in the pursuit of a job as a consultant, as the following account states. One interviewee reported having four post graduation qualifications in different fields prior to commencing vocational training as a GP.

The above support Smith’s (1980) finding which highlighted that the UK qualified and overseas-trained South Asian GPs were a somewhat contrasting group in that they were late entrants and more likely to have higher postgraduate qualifications as well as many years of hospital experiences. The interviewees talked about a combination of things such
as several years of hospital experience both in the UK and the country of origin and the integration of their own cultural values into their roles as GPs:

Having done different jobs in India and the UK which gave me in total 14 years experience was very helpful because you could help the patients in General Practice a lot. Then we got involved with the elderly, we had to do that. There was also community cohesion, so you were much more than others at that time. I could advise the elderly because I had worked in geriatrics, and that helped me a lot in General Practice with people and patients, they were elderly, what to do with them and how to do it, when to get social workers involved or physiotherapists or whatever is required for the care of the elderly... I do think though that I incorporated my own cultural values into how I practiced, for example, we take care of our elderly much more than in this country (gpm6).

Being trained in ex-colonies where medical the model mirrored the UK model and the ability to use creative thinking skills was described as an asset by several interviewees:

... our medical training was based on similar models of the UK curriculum, but because we had limited resources in our countries, we were so used to thinking outside the box and we understood things better. Many medical students appreciated how we were able to explain things better (gpm6).

The interviewees seemed well aware of their expertise and self-worth in terms of their experiences in the country of origin, which Zhou (2008) referred to as an imported individual-level trait:

They [British] did not have the experiences that the foreign doctors brought with them. You do medical training but your life experiences and professional experiences differ. You see other people doing things sometimes right, other times wrong, then you learn. In our countries we have a lot of hands on experiences because we have a lot of material, population; you deal with a lot of people both medically and surgically, we see more complicated cases in our countries than here by comparison, the consultants here used to depend on us a lot more because of our experiences. They used to let their own go and say to them, in time you will also learn (gpm8).
Another interviewee talked about how the experiences in the country of origin and in the UK helped him and his colleagues to become successful physicians in the primary care setting:

*We already knew many practical things, taking blood, lumbar puncture, drainage of fluid from lungs; we knew all that because chest problems are common in Pakistan. You see over there, you see a lot of ill patients and you see a lot of medicine and in one year what I learnt in Pakistan, you learn here in five years, so all that experience that we brought with us. Because, there is so much poverty in Pakistan, no proper organised health system, you mostly work on your own initiative; you see in Pakistan, they didn’t used to go to until they became really ill. I worked in chest clinics and my experiences in Pakistan were so useful here because we see a lot of chest patients in Pakistan, they had TB, smoked, a lot of patients with cancer etc. I knew what investigation to undertake as I had a lot of experience in this area, the more you do, the better it becomes. In hospital work in the UK, I was responsible for 100 patients in four different wards; consultants used to be in different hospitals and you did most of the things without them even knowing because they were not contactable (gp3b).*

A few interviewees (3/27) stated they had brought with them the experience of working in the armed forces in the country of origin and that this provided useful management, leadership and organisational skills. Some interviewees stated that they were encouraged to apply for GP posts as others had envisioned the benefits of appointing overseas-trained South Asian doctors in certain geographical areas:

*I was invited to apply for this post. Before the interview, one of the panel members said to me, look, we need people like you, you are very experienced and highly qualified, we would like to offer you the post but on one condition that you will remain in the North West (gp7m).*

Group-level characteristics include predisposing factors such as migrants being a selective group such as in this study, culture, and aspiration levels, the possibilities of resource mobilization, ethnic social networks, capacity for general organising, and government
policies that either constrain or facilitate the acquisition of resources (Aldrich and Waldinger, 1990). Culture refers to the cultural repertoire that migrants either import or adopt in the host country. They are group specific, behavioural patterns, distinct group traits, social structures, collective resources, and coping strategies in the form of imported and reactive cultural values (Zhou, 2004). Portes and Zhou (1992) use two concepts to sum up the group-level characteristics, ‘bounded solidarity’ and ‘enforceable trust’. Bounded solidarity is produced by migrants’ overseas status and by being regarded as ‘culturally distinct’ which then intensifies feelings of shared cultural heritage, and reciprocated obligations among co-ethnics. Rather than having spontaneous feelings of solidarity to other co-ethnics, bounded solidarity is based on the ‘enforcement capacity’ of the ethnic community that regulates the individuals’ behaviour within the community and its power to use sanctions against anyone who violates the expected norms in that society. The key enforcement mechanism applied to deal with anyone who violates it is ‘enforcement trust’ and the community has the ability to honour status to individuals or exclude them. The above mentioned group-level characteristics are rooted in ethnic social structures that produce social capital and facilitate entrepreneurial growth.

The interviewees in their accounts emphasised ‘we’ when talking about innovations and frustrations. They functioned collectively to reinforce values and norms that they derived from their own cultures and mobilised resources to achieve their goals. The doctors in the study also acknowledged each others’ expertise and called upon their own cultural resources in problem and creative thinking techniques such as the collective reciting of poetry, and used idioms from their own languages from which to draw strength. An example is when an interviewee was talking about losing half of his patients’ list when he took over his practice from a white doctor. He believed that his race had played a part in this process. He explains how he coped with the challenges involved with this situation, reciting the following verse in Urdu:
**Baad e mukhalif se na gabra e eqab**

**Ye to chilti and tujec uncha uraney kaliey**

[Translates]: Oh bird, don’t get troubled by the strong wind blowing from the opposite direction, It blows only to make you fly higher)

Another doctor recited lines from a late 13th century Persian poet that are also commonly used in conversations by Iranians today:

*There were tensions/conflicts between us [Asian] as there was competition among them and backbiting but I remembered what Shaikh Saadi had said that you must not backbite and say things about others that you cannot say to their face...*(gp8s).14

The above account shows that there were tensions and conflicts among the overseas trained South Asians doctors. This is further discussed in section 6.6. The evidence shows that the coping strategies employed originated from cultural resources such as the following:

*... that was my philosophy, only when the right time comes, you get what you want, your own destiny determines what you get...*(gp5s).

Levitt (1998) refers to the role of social remittances in promoting immigrant entrepreneurship. Social remittances are ideas, behaviours, identities and social capital related to democracy, health, and community organisation that migrants bring with them from their home countries and then culturally diffuse within the new settings. Levitt (1998) states that the impact of remittances is heightened if the messenger is a high status individual who is able to give something a new meaning, so that others occupying similar status positions readily adopt them, following their peers to become more like remittance transmitters. This was evidenced in the accounts by several interviewees who had introduced many new initiatives, revitalising their practices and equipping them with

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14 Shaikh Saadi , full name in English: Muslih-ud-Din Mushrif ibn Abdullah) is one of the major Persian poets of the medieval period. He is recognised not only for the quality of his writing, but also for the depth of his social thought. Levy, R. (2012) *The Persian Language (RLE Iran A)*: Routledge.
modern facilities. The account below shows how one interviewee became a social remittance transmitter:

*Others started following me and they were incidentally most of them Asians but local GPs as well (gp9s).*

The majority of the interviewees described getting involved in poetry gatherings which served as a forum for reviving strength and enthusiasm. They believed that their experiences of exclusion had created a side to them that was not apparent in their countries of origin. The interviewees’ accounts provide evidence of how they reflected on many aspects of the cultural context of their personal and professional lives throughout the interviews. They incorporated cultural values in their practice model, for example, the values of social justice that acknowledge the equal worth of all citizens was mentioned by almost all interviewees, who frequently compared things in the UK, with their country of origin, and felt privileged that they had access to opportunities where they could help the needy. Their accounts also frequently showed the prominence of their professional identities, where emphasis was placed on meeting the healthcare needs of the deserving. Many of the interviewees talked about having had challenging life experiences in the country of origin, and appeared to have a heightened awareness of the needs of the deprived.

A positive attitude to work was something that also cropped up in many of the accounts which is likely to have facilitated the creation of an entrepreneurial spirit. Interviewees also referred to being appreciated for providing pastoral care, which they believed was a vital aspect of their practice:

*I think the word ‘hardworking’ had not been invented in the olden times (my time), all we knew was that we had to work and work with passion not for the sake of it. We treated work with respect and did not count hours or weeks, we had love for each other and regarded each other with a lot of respect, and*
these things are priceless and rare these days. These things were not taught as part of our medical training in India, but we learnt them from our experiences in the community. It never comes to my mind even today that any of my patient is wasting my time because I think there must be a genuine reason that he/she is taking time to talk to me. The patients here liked us more than the local doctors. We were more caring, I think it was to do with that (gp6b).

The interviewee refers to the cultural and experiential learning that as a group the overseas-trained South Asian doctors are likely to have imported. One third of all interviewees asserted that white patients often showed a preference for an Asian doctor, which the interviewees believed related to the doctors’ caring attitude. It is also possible that the white patients who were likely to be marginalised within the geographical contexts that the majority of the overseas-trained doctors were operating in, found such interactions less threatening, and were thus able to form more meaningful relations.

Once established in their practices, many of the interviewees said that they became involved in training others, mostly GPs with South Asian origins; this may be related to the fact that the geographical locations often did not attract white doctors. As doctors in the study had more experience and skills than the UK-qualified doctors, their contribution as trainers was likely to be invaluable. One interviewee commented on the contribution that he and other overseas-trained south Asian doctors made towards the development of General Practice:

There is the Royal College of General Practice; they laid the rules, for training. A lot of us became trainers; we contributed in its [general practice] development. We took trainers and passed on our knowledge, our experiences on to the new learners by letting them watch us how we do it (gpm5).

Many interviewees talked about being an informal mentor and assisting other overseas-trained South Asians, as well as offering cross-generational support to those who were younger, something that can be regarded as a distinctive contribution to the area of
entrepreneurship. The following interviewee talked about how he was motivated by his own previous negative experiences, and passed on his knowledge regarding know-how and the skills he had acquired:

*Because my experiences were so bad, I was more determined to be entrepreneurial, now all the doctors that work with me are very happy with me. I make sure that they don’t go through the same experiences that I went through.*

His account below shows how the older generation of overseas-trained South Asian doctors was involved in making life easier for the new generation:

*I had a phone call the other day from a young female GP in another borough in Greater Manchester; she is from India, has not been long in the country and was having some staffing problems. I went over and just talked to her in our own language and that alone was so comforting for her, told her some tips and after two hours talk, she said she felt so much better and had regained her self-confidence, whereas before, she thought she could not hack it any more. I told her, ‘don’t feel you are on your own, come and talk to me whenever you need’. I think overseas-trained doctors take time to adjust unless they are flexible and get into the system, working like people want you to work, it can be difficult. You see GPs are independent and it’s like a business so there are two aspects to it, clinical and business, you have to manage both (gp1m).*

The fact that the young female overseas-trained doctor was able to pick up the phone and seek advice from a senior colleague with years of experience in an informal way confirms the numerous benefits of co-ethnic networking that is not available from the mainstream networks. Saxenian (2001) talks about the value that networking creates and cites Mohan, one of the Silicon Valley’s entrepreneurs, who talked about how the presence in itself of his organisation (The Indus Entrepreneur) created confidence in the community. He added that confidence provides individuals with a safety net, and a feeling of security that they can approach someone in times of need. It helps with risk management and networks help improve one’s ability to manage such risks effectively. The above process turns into a self-
reinforcing process as one entrepreneur then creates five or ten more entrepreneurs who then create another ten. Mohan added that the chances of taking risks are reduced in the absence of role models and confidence builders that one can turn to.

The doctors’ entrepreneurship is evidenced by their risk taking attitude, their innovation, and networking with other overseas-trained doctors, which has been co-produced by the very nature of the opportunities available, as well as by the individual and group characteristics and their motivation (Zhou, 2008). The following female interviewee’s account shows how networks, support, a sense of one’s own agency, and a business-like approach can produce positive outcomes:

_We purchased land and had the surgery built, we borrowed money and then paid it off, it was risk taking, patient list was not long, we were quite young and we were going to work for quite a long time, it was an investment, even if we didn’t work, we will get rent paid, it was a business enterprise (gp11s)._  

The buildup of ethnic residential areas to which patterns of chain migration and majority group discrimination contribute, present ethnic entrepreneurs with opportunities. The account below provides evidence of how the clustering of doctors and an Asian community may have occurred on a broader scale:

_We started off as husband and wife, then we looked for another partner, then we took another doctor, we had so many Asian patients, I think they were gravitating to this side of the city because people look at what amenities there would be in the area when buying a house, and having an Asian doctor for somebody who doesn’t speak the language is an important aspect and to be frank, an English doctor does not even like to look at such type of practice let alone work with Asian patients (gp11s)._  

She adds that both types of the patient population appreciated the service they received:

_It’s helpful if the doctor speaks the language and knows the culture, patients were happy to receive the service, they had respect for us, they appreciated as_
The English patient is verbally very appreciative and can’t stop thanking you, I am grateful, so nice of you, thank you very much, sometimes they would bring flowers, you helped me and I brought you flowers, presents on Xmas, they were very good. Our own patients were appreciative but as you know they didn’t express as much as the English did (gp11s).

As stated elsewhere that the marginalised practitioners and marginalised patients produce encounters which appear to be more reciprocal in nature. Charlesworth (2000, 138, 284) referred to both white and working class Pakistani people in own study focusing on Rotherham, an ex coalmine town in South Yorkshire calling it as ‘linguistically dispossessed, sensorily impoverished and perceptually deprived’ full of people who consequently are unable to achieve any significant form of self-realisation. The patient population in the case of overseas-trained doctors is likely to fall into the above category and includes those who may be more appreciative of clinical encounters with non-traditional medical practitioners. Beagan (2000, 1254) points out that Western biomedicine has not always done well by patients where there is significant difference between the patient and the physician, the latter being mainly white, upper- or middle-class, heterosexual men, and names a few examples such as the over-prescription of tranquillizers, the criminalisation of abortion and birth control, the use of unsafe medical devices such as IUDs and breast implants and the history of medicine’s mistreatment of women with the evidence of power inequality.

6.6 The Downside of Ethnic Entrepreneurship

Entrepreneurial activity is not carried out in isolation and its dynamic nature requires linkages or relationships between key components of the process (Aldrich and Zimmer, 1986). The success of ethnic entrepreneurship has been explained by individuals’ personal willingness to engage in hard work and solidarity. This helps to provide the resources necessary to achieve their economic goals and compensate for the automatic set of
resources that the privileged social classes entering entrepreneurship seem to have (Light and Karageorgis, 1994; Light and Gold, 2000).

In understanding the entrepreneurial activity of members of ethnic minorities, the significance of ethnic resources, meaning resources gained through ethnic solidarity and ethnic social relationships, is emphasised in the framework of ‘ethnic’ versus ‘class’. As ethnic entrepreneurs lack access to class resources, for example, economic capital, education, symbolic capital and access to influential economic and institutional networks (Light and Gold, 2000), the available resources are accessed instead through ethnic solidarity and ethnic social relationships. It is the social embeddedness of ethnic business whereby social relations and acquaintances become networks that generate the trust required for entrepreneurial activity, and also provides support, preventing any breach of trust in terms of economic transactions. Reliance on family members is regarded as a considerable part of the ethnic resource (Light and Gold, 2000). It has also been associated with exploitation within the realm of entrepreneurship (Werbner, 1990).

One third of the doctors in this study talked about being exploited by their colleagues who had taken them on based on mutual trust but the working relationships became difficult:

> I found out that a doctor [Asian] was looking for a GP for their practice. I worked with him for a short while but our own people are also very clever as well, they will step over you to get to the top if they can. There was no prospect there either to have a partnership (laughs). Some people have greed, they want to keep all the money to themselves, it was like that. I was employed as a salaried partner. The practice partner kept saying yes you will become a partner but only verbally; this did not materialize (gpm4).

Trust was described as a key feature in all transactions; however, it also cropped up when the interviewees were discussing in exploitative relationships:
At first, the practice partner made many promises but afterwards did not adhere to them. I worked for a year and a half with him. He was not prepared to give a written contract, he said just work, when the payment time came, he did not give an equal share. He said you will have to accept what I give you. I told him it was not fair, not to have a written contract plus, salary not being shared out to both of us even though I was the one who was doing more work than him. I said, there is no trust here, you are saying to me that just accept what I am getting and do my job. There is no discussion about any decision that needed to be made re work, practice business etc. And you keep all the money to yourself. One day he came and said this is not working out and I want to end this (gpm1).

The above account shows the informality of the recruitment process and lack of adherence to employment rights which is unusual in professional jobs. It appears from the account below that the PCT had failed to intervene directly with the practice partner; this may be related to their reluctance to get involved in litigation which might be perceived as a potential race issue:

_I went to talk to the chief executive of Family Health Services Authority in PCT. I told them that it was not working out and that it was very problematic for me. They said they had known about this practice’s history, they said, don’t resign from the practice. She said, I advise you to start another single handed practice adjacent to the other practice; we need more doctors in this area. I thought about it and then decided to act on PCT’s advice. I had not picked up before that this practice partner [Indian origin] had got some negative reputation. I found out later that he had done this before. So I started my own practice from scratch (gp1m)._ 

It is interesting to note that the PCT opted to ease the obstacles blocking the entrepreneurial initiative of the above interviewee by suggesting the opening up of a whole new practice that would undermine the business of another South Asian doctor. One explanation for this is that the PCT needed more doctors; another may be that it may have been a far more challenging task for the PCT to directly challenge and deal with the
competence issues of an overseas-trained South Asian doctor as it could lead to potential litigation and race issues. The following account suggests that the doctors felt that the PCT were selective regarding who they helped and why:

I was being treated not equal and was doing more than my fair share of the work and not getting paid for it. I complained to the PCT and even the BMA. They said that it was a private arrangement between me and the other Asian doctor, and there was no contract in place, therefore there’s nothing we can do (gp7s).

Exploitation was reported as perpetrated by South Asian as well as white GPs. The interviewees’ accounts illustrate how overseas-trained South Asians were stereotyped as hard working doctors and thus taken on by white practitioners. Expressions such as ‘made to work like a donkey’ were used.

Personal networks appear to have had their downside, working against individuals as others had access to personal knowledge about each other, and that among other things, regions and religions were also taken into account when offering employment:

With our GPs, they knew inside out how hard it was to find a job, so they made use of their positions and said to the GPs, these are our conditions, come and work for us if you want. Then of course, you are a junior, and the senior is going away for three weeks or four weeks, going away tomorrow, so the junior had to put up with that. I know there was a bit of prejudice among Asians based on region and religions but not a lot, I think it was to do with personalities as well, I took Indians and Pakistani both (gp9s).

Another interviewee also describes his experiences of exploitation,

Yes it’s sad, very, very sad. Not only that, you spend two minutes and when you see this man is a bit challenging... kaka, [referring to male as boy in a patronising manner] get out. As long as you’re not talking about money, and you’re working like a donkey so then its fine, the problem is, as long you’re not challenging, I’m working so much and I’m getting this much share, you’re working this much and getting this much share, until you bring those issues up
you have very good excellent relations, the very minute you bring those things in...you are out (gpm4).

It would appear from the above account that the overseas-trained south Asian may have initially lacked in people and finance management skills for their newly acquired role, or may have financially struggled in setting up a practice. However, their success as entrepreneurs was not viable without the support of other overseas-trained South Asian doctors who were prepared to work under prescribed conditions until they reached a stage where they too could become fully fledged entrepreneurs.

Securing employment in a GP practice was described as the greatest difficulty by several of the interviewees, but the ethnic networks provided refuge for such disadvantaged individuals. However, for many, it was also short lived. One interviewee described at length how his multiple identities did not neatly fit, thus allowing him to experience bounded solidarity, as he was of Indian origin with a Muslim background and not accepted by Pakistani Muslims or Indian Hindus.

It has been argued that ethnic entrepreneurs hire employees of their own ethnic group and use their personal and ethnic networks in order to recruit new employees (Levent et al., 2003). The interviewees’ accounts show that there was more to the recruitment strategy employed by the doctors in the study than simply taking on another co-ethnic as an apprentice or a partner. The following interviewee explains how he looked for someone who shared his passion:

I started everything myself, I built this whole baby clinic here and child health which is now 23 years old. The first baby born is 23 years old, the first lady that came pregnant, antenatal clinic, the babies whose injections I gave, the childhood immunizations I gave, and those who were born and came home after the hospital one or two days old and I went home and examined those, they are becoming mothers now or fathers you know. Yes, this is how it works you know and every practice does the same, but how is this man, [potential
[applicant] how does he deliver health care? How can he improve his services? And then what... how you can improve, how your expertise can fit into the practice and how the practice can develop and go forward rather than dragging backward (gpm7).

Organisations are said to recruit like-minded people. The above account shows that the recruiting of GPs of similar cultural background was based on a similar principle and the qualities that were sought out included the ability to bring the same level of passion as the employer, demonstrate creative thinking, have vision, expertise and be diligent and determined.

The interviewees often looked for further opportunities and regrouped with other individuals who had had similar experiences as well as joined practices managed by white British doctors, taking opportunities which were initially not available. Though these examples show the negative aspects of bonding social capital and how opportunists within the group were willing to exploit each others’ vulnerable position, they also show that bonding social capital played an important role in enabling interviewees to later access bridging social capital which was not available in the first instance.

Unwin (2001) points out that it is often assumed that racial discrimination means white people discriminating ethnic minority people, whereas it can work both ways. The author refers to accusations that overseas doctors become ‘more British than the British themselves’ upon receiving consultant status. Unwin’s analysis of such a situation appears plausible as he argues that this behaviour is described as an outcome of a system (oppressive) where one is required to behave in a certain way in order to get on.

6.7 Social Entrepreneurship

As described in the literature review, social entrepreneurship differs from entrepreneurship in that the former has a social value attached to it and social entrepreneurs undertake to
address a need that the welfare system either cannot or will not otherwise meet. The test of its value can be taken by establishing the extent it would be missed if such initiative had not been taken up (Thompson, 2002, 414).

Evidence from the interviewees’ accounts suggests that the roles played by them also merit them being labelled social entrepreneurs. For example, the following interviewee believed that the Asian women in the area should learn English, and initiated a self-help project in which he used his networks, and status as a healthcare professional:

*I organised teaching of English language for Asian women in the area. I also felt that by putting English female patients of mine in touch with the Asian women will create an opportunity of volunteering, both will benefit from this group, the Asian ladies could practice learning and speaking English and the English women could learn about the Asian cultural aspects. But I had a lot of criticism, e.g. men said that these English ladies were coming to their homes with skirts on and that was unacceptable to them. I could not understand why they were objecting as the women were supposed to teach women and I don’t know what their problem was, most likely men very critical as they wanted to keep hold of the control in the household and did not want their wives to become aware of their rights (gp11s).*

The above example shows that the healthcare professionals may have been involved in both issues of cohesion and conflict in the communities that they were serving. The interviewees also talked about being involved in fundraising activities run by their local Rotary and Lions clubs to raise money for equipment for local disabled people. Many of the interviewees (two thirds) talked about their extensive involvement in charitable work in the countries of origin that would be classed as social entrepreneurship. The interviewees described at length activities that they were heavily involved in, and that were geared towards meeting the healthcare needs of the most vulnerable sections of society in the country of origin, utilising their specialist knowledge and financial resources gained in the UK.
The interviewees’ accounts confirm that they are involved in the exchange of social remittance and transnational activities, which will be further discussed later. The accounts also show that these health care professionals are in an ideal position to help western countries to offer aid to developing countries.

6.8 Summary

This chapter set out to examine the entrepreneurial behaviour and contribution of overseas-trained South Asian doctors in the UK, and the empirical evidence relating to the experiences of doctors in the study with the existing theories of entrepreneurship. The investigation related to question four of this study.

The discussion explored the factors that led to the doctors’ entrepreneurial activity. The first section of the chapter looked at the push and pull factors responsible for them entering into General Practice. It was interesting to note that, when they arrived in the UK, the interviewees initially wanted to be selected on merit; however, the process of negotiation of entry into General Practice shows that the experiences of exclusion/marginalisation in the medical labour force contributed towards the strengthening of an ethnic identity among the doctors in the study. In managing the exclusionary practices that they had been subjected to, ethnicity was used by them to their own advantage. The interviewees used their own agency to revitalise existing GP practices, filling the gaps in the market, creating not only their own jobs but also those of their counterparts, often with similar backgrounds. The detailed accounts show that the specific individual-level and group-level characteristics that they imported from the countries of origin, in the form of cultural resources, greatly facilitated entrepreneurial activity, however, this form of social capital also contributed to their exploitation and exclusion.

The evidence shows that issue of resource mobilisation in the geographical locales that the interviewees worked, was facilitated as these doctors were able to draw on their
connections with other doctors of similar backgrounds. To an extent, they adopted some of the exclusionary processes they themselves experienced to their own advantage, either out of necessity or lack of alternative options. They were able to build special relationships with a wide range of people and deliver specialised services to communities and patients. They were able to combine resources in novel ways so as to create something of value (Aldrich and Waldinger, 1990).
Chapter 7: Identity and Belonging

7.1 Introduction

In the previous two chapters, I discussed the empirical evidence concerning what Bhugra and Becker (2005) describe as the first two stages in the migration process, that is, the pre-migration stage involving decision making and preparation leading on to the physical relocation of individuals from one place to another. The authors also refer to a third stage which is concerned with post migration and how migrants become absorbed within the social and cultural framework of the receiving society, which is examined in this chapter.

In this section, I will discuss the empirical evidence in relation to the identity dynamics of the interviewees, how different aspects work to constitute identities for the interviewees and how they negotiate their identities through some of the above cultural attributes such as place, ethnicity, Britishness, religion, gender, class and profession. The evidence relates to research question 3 which asked how the different contextual factors have impacted on the overseas-trained South Asian doctors’ identities and their perception of the communities around.

I will begin by discussing the contextual characteristics of the case study areas which may facilitate or inhibit integration, followed by a discussion as to how ethnic identification intersects with other identifications such as place, class, profession and gender.

7.2 Contextual Characteristics of Case Study Areas

Barnsley-Sheffield-Manchester

As described previously, Barnsley is a predominantly white area with a significant working class rural community, who in the past heavily depended on its coal mining and glassmaking industries. Since the closure of the coalmines in 1994, the area has experienced a lot of unemployment. It has a low ethnic density in comparison with
Manchester and Sheffield and only a 0.9% BME population in 2001, 0.3% of whom were of Asian origin, the largest group being of Indian origin (0.2%)\textsuperscript{15}. The Census 2011 shows that these figures for the Asian population have remained the same, although the overall BME population has sharply increased. Barnsley has historically had a high density of overseas-trained South Asian GPs - making up 38% of the total GP workforce in 1992 (Taylor and Esmail, 1999). This over-representation of overseas-trained doctors in General Practice in the area may be attributed to its contextual characteristics such as the level of deprivation, making it a less popular area for UK qualified doctors and thus less competitive for the former group.

Barnsley council’s initiatives related to ethnic relations are historically not as well established as in Manchester and Sheffield. An umbrella organization, the Barnsley Black and Ethnic Minority Initiative (BBEMI) was set up in the area in the 1980s to promote good race relations and racial harmony amongst BME and the wider community of Barnsley. As the ethnic communities are small in size, the social and cultural events are organised jointly. The British National Party (BNP) is known to have a stronghold in the area. The news of a local mosque being burnt down in the 1980s would suggest that there has been hostility towards the borough being multicultural.\textsuperscript{16} Barnsley Council Online\textsuperscript{17} refers to growing concerns about the increase in racist incidents across the borough, which led to the establishment of The Barnsley Racial Harassment Project in 1997.

Sheffield, in contrast, is a large urban area with a much higher proportion of BME population than Barnsley. The history of settlement for BME communities in Sheffield is linked with the post-war labour shortage in traditional Sheffield industries such as iron,

\textsuperscript{15} Census 2001.

\textsuperscript{16} Lord Nazir’s paper \textit{Muslims in Europe, Understanding and Responding to the Islamic world} at St Antony's College, Oxford on 25-26 April 2003, http://www.sant.ox.ac.uk/ext/princeton/pap_ahmed.shtml

\textsuperscript{17} http://www.barnsley.gov.uk/
steel, which attracted migrants from the Indian subcontinent and African Caribbean countries. Prior to this period, Sheffield experienced the presence of Jewish, Polish, Irish, Somali and Yemeni people in the city. However, the proportion of BME people has been increasing and was 8% in 2001. It included people of Indian (0.6%), Pakistani (3%) and Bangladeshi (0.4%) origin, increasing to 1.1%, 4% and 0.6% respectively in 2011. Sheffield also has a slightly higher proportion of people in mixed groups and Chinese people than the national average.\(^{18}\) Sheffield also has had a high density of overseas-trained South Asian GPs, and these made up 14% of the total number of GPs in Sheffield in 1992 (Taylor and Esmail, 1999).

The city has well established BME religious and cultural organisations as well as mainstream initiatives addressing the needs of its BME communities. The city has had forums such as the Sheffield Committee for Community Relations, which was founded in 1967 to promote equality,\(^ {19}\) and events to mark Black History Month have been held since 1997 to celebrate the diversity of the city.\(^ {20}\) Despite having sizeable immigrant communities, the city is reported to have had fewer racial tensions when comparison with other cities in the UK and certainly has escaped the race riots that some other British cities have witnessed (Taylor et al., 1996). Following the decline in the steel industry, there was a shift away from employment in manufacturing industries to jobs in service industries, as in other cities in Britain, and the city has affluent as well as deprived areas. Taylor et al., (1996, 205) refer to the particular class dimension of the local structures of Sheffield and

\(^{18}\) Sheffield City Council, 2001 Census Topic Reports, Ethnic Origin, Corporate Policy Unit September 2003

\(^{19}\) Report of Sheffield Racial Equality Council, 1 April 2006 to September 2007
http://www.charitycommission.gov.uk/Accounts/Ends34%5C0001112134_ac_20070331_e_c.pdf

\(^{20}\) Black History Month
Manchester in their research, where new immigrants of different class backgrounds are presented with a different mix of opportunities and problems.

Manchester is a major urban area and differs from Barnsley and Sheffield in relation to its ethnic density. Originally, only Manchester city was chosen for this study, however, due to recruitment difficulties, other boroughs of Greater Manchester were also included such as Tameside and Rochdale, although the majority of the doctors in the sample are from Manchester city. The BME population made up 19% of the total population of Manchester in 2001. The proportion of BME included people of Indian (1.5%), Pakistani (6%) and Bangladeshi (1%) origin which increased to 2.3%, 8% and 1.3% respectively in 2011. In the 2011 Census, Tameside had 5.9% South Asians, which predominantly included people of Indian (1.7%), Pakistani (2.2%) and Bangladeshi heritage (2%). Rochdale had the highest percent of South Asians (13.5%) including people of Indian (0.5%) origin, a much higher proportion of people with Pakistani origin (10.5%) and Bangladeshi heritage (2.5%). The GPs who qualified in South Asian countries made up 30% of the total GP workforce in Manchester city in 1992 (Taylor and Esmail, 1999).

Jones and Snow, (2010) provide a historical view of the formation of BME communities in Manchester and state that the earliest migrants to the city were Jewish people fleeing from persecution, followed by Italians and Irish, Poles and Chinese people, who worked in different areas of the labour market such as in the textile, construction industries as well as peddlers, hawkers, shopkeepers, cotton and silk merchants. The migrants also included professionals, students and West African and West Indian seaman, other workers and their families. Diversity began to be reflected in the type of restaurants in the city, with African and Asian restaurants starting to cater for the diverse needs of the migrant population. The Asians mostly arrived after the 2nd World War although the presence of Punjabi traders was said to exist in the 1930s. The Asians mainly worked in the cotton mills of Lancashire and were predominantly of Pakistani origin. In
the 1960s, the NHS appears to have relied heavily on overseas junior doctors in the city’s hospitals as they represented between 30-40% of all junior doctors. Indian and Pakistani-trained doctors were also said to be propping up the city’s GP and dental practices. Social and cultural BME organisations have existed in the city since the 1960s. Racial tension/violence has surfaced in the city from time to time, and there have been several racially motivated murders in Greater Manchester, Ahmed Iqbal Ullah, a young Bangladeshi schoolboy, being murdered in 1986 (Brah, 1996). Manchester is the fourth most deprived area on the Indices of Multiple Deprivation (IMD) which has a bearing on the service sector especially the NHS.

7.3 Place-based Identity

7.3.1 Introduction

In this section, I will look at how the interviewees happen to occupy particular places, their social and doctor-patient interactions, and their adaptations to fit in, whereas the experiences of racism and the coping strategies section will explore the interviewees’ own perceptions of racial prejudices as experienced by themselves or their colleagues, and issuing from patients/other professionals/communities, together with the strategies they employ to overcome such oppression.

7.3.2 Settlement in Respective Areas

Settlement into Barnsley resulted via two routes. One route involved responding to job advertisements and moving from other cities to gain independence from group practices that the interviewees previously worked with. The second route described by two of the interviewees was to establish links in the area during their vocational training in the area, and then be offered a job following completion of their training. The female interviewees had existing networks in the area through spousal links who were working as local hospital
doctors. The interviewees’ accounts suggest that the tradition of migrant GPs working in the area was well established and jobs were becoming available through departing GPs of Polish and Irish origin, who were reaching retirement. The interviewees from Sheffield and Manchester area also responded to recruitment drives. A couple of interviewees from Sheffield stated that they had had other offers from other ethnically dense areas such as Leicester and Birmingham but their preference for Sheffield related to its leafy suburban characteristics. The average length of service for the doctors in the case study areas who remained in the same place throughout their GP career was well over 30 years which shows a considerable loyalty to patients and communities. In the following section, I will discuss the residential pattern of the interviewees and their sense of belonging to their local areas.

7.3.3 Neighbourhood Areas and Communities

A common assumption held in the causal story of the community cohesion agenda is that different minority ethnic groups actively choose to live in segregated communities (Robinson, 2005). The interviewees in all three case study areas described being part of a pre-dominantly white middle class neighbourhood, where most other professional people lived. The finding in this study is in contrast to the above assumption and suggests that elites may choose to live with other elites in the area.

Their accounts show that they had formed a close bond with their neighbours, who had been, like them, long term residents in the area. They talked about memories of raising their children together and different aspects of physical neighbourliness such as how their neighbours cared for their houses while they were away or helped dig snow from the drive in winter. Their detailed accounts illustrate that they had a fair amount of knowledge of the backgrounds of other residents in the area, for example, one interviewee in Barnsley, described her neighbourhood area as follows:
This area it’s all architects, medical, and he’s an accountant he’s used to be a headmaster, he’s retired and the first one is also a teacher, she’s a teacher and he’s working, he’s having some business I think and erm here is all the retired people except these people, he’s an engineer and she’s a teacher, and they are... next one is retired, the next one is a young couple, they just bought that house you see, so he’s working in graphics and she’s doing a part-time job, working for her husband, their children are the youngest children in the area, 17 and 13 (gp1b).

For most of the interviewees, the contact with neighbours took place over the fence or occasionally their neighbours visited but this was not always reciprocated as the following interviewee states:

We do interact with their English neighbours, they come to us but they don’t invite you to their homes much (laughs), the English are well known for being reserved and we don’t mind that (gp6b).

The above interviewee views the behaviour of his neighbours in the context of English culture, while another interviewee echoed the above and commented that she too had adapted to that lifestyle:

All my neighbours are exceptionally good, we may not go to each other’s house for a coffee morning but I know them well, they know me well. I also like that, rather than chit-chat, I also like that and they also like that, we can talk standing in the drive way for hours, but sometimes, I mean they do invite, if there is any special occasion or for a drink near Christmas, new year time (gp1b).

She describes the composition of her neighbourhood and refers to other Asian doctors living in a cluster:

I’m the only Asian doctor in this street, here, but, on the other side of it... there are quite a few Asian doctors, all are GP’s, I think there are about... at least 12 Asian doctors (gp1b).
Barnsley is made up of several small remote villages. Some of the villages appear to heavily rely on the services of overseas professionals. Several interviewees’ accounts show that it was a norm to actively belong to local and global communities:

...the people that live nearby, we don’t see them very much... they are also professionals, they go home over the weekends, like Belgium, France, They are all international workers, there’s a dentist in our village from Belgium, he goes back to Belgium to visit his family every fortnight, goes on Friday and comes back on Sunday. There’s a doctor over here from Spain, a doctor from Germany working over here in our village (gp4b).

Also, close friends described as living in regions other than Bransley and with whom a close bond was maintained, were mentioned. The following account refers to meeting one’s ‘own people’ which suggests that this was a way of affirming their Asian identities:

My friends are always there... they live quite a way from here, I mean I have a friend in Oldham, Preston and Surrey... from ‘Madras medical’ you see, and so every year May Bank holiday weekend event, we try to attend that, just see your own people and chit chat.... So it is nice (gp1b).

Interviewees in Sheffield also described living in pre-dominantly white middle class areas where they believed they had been accepted partly due to their professional status and social class which are interlinked. However, the areas did have other South Asian doctors which the following interviewee refers to, suggesting that being perceived as middle class along with the presence of a few other Asians may have been perceived to offer a buffering effect in relation to overt racism:

My wife (laughs) and I enjoy the freedom we have, apart from a little bit of racism which is there, but most of the places it does not matter. When I wanted to buy a house here which is a predominantly white upper middle class area, I was the only brown person in this road at that time, nobody objected to that, there are some ghetto areas, white areas, black areas. If I had bought a house in some ghetto white area somewhere else and if we started living there, the neighbours may start making our life hell. They all came along and they
welcomed me here, there’s a few Asian doctors here, I think it’s about the level of education, I am not saying that the educated aren’t racist, they may be but they keep it under the surface (gp9s).

Reasons for the gravitation of people with a minority background to form such instances of clustering have been described as a vital resource that offers mutual support and security in the face of hostility from the majority ethnic population as well as economic reasons (Johnston et al., 2002; Wilton, 1998). Availability of culturally sensitive services, religious and recreational facilities and shopping opportunities are also associated with some of the practical benefits of minority ethnic population clusters (Robinson et al., 2002). The above interviewee believed that the middle class nature of the area has offered him protection which a ‘ghetto’ area may not have done. In other words, living with other elites in the area is considered as a protective factor. He did not deny the existence of middle class racism, but argued that it is kept ‘under the surface. As educated people are likely to be more aware of equalities legislation and the implications of explicitly contravening this, it could be argued that they are more cautious in terms of self-exposure (Blinder et al., 2013). The interviewee also talked about being part of a middle class close-knit suburban community where neighbours just casually drop in whenever they like:

All these people, they know me and there’s no problem, the other day, this guy, Professor of Surgery, he (white) walked in, he goes ‘I want money for charity’ (gp9s).

Recalling further memories, the above interviewee mentioned that in the 1970s, there was a doctors’ club in the neighbourhood where local doctors met up regularly, and where he was the only non-white doctor. He was aware of the exclusion of other Asian doctors in the area but uncertain why that may have occurred. The fact that he married an English woman may well account for this inclusion, as Lahiri (2000) points out those with English wives are likely be more readily absorbed into local communities. According to the exchange theory of Merton (1941), educated African Americans traded their socio-economic status
and endeavoured to maximise their gains through marriage with lower middle class white partners and trading their socio-economic status in order to achieve the social status that was attached to having a white partner. The interviewee went on to explain the reasons that lie behind working class racism and is based on a different kind of prejudice:

*I think, competition of resources is the main thing actually, e.g. one household may have a Mercedes and they have 17 children and are on benefits, whereas the next door may be struggling to put the food on the table, they get irritated that he is not getting same as him, working all hours Godsend but here nobody is claiming anything (gp9s).*

The interviewees in all three areas described being accepted by their elite neighbourhoods and were aware that their symbolic capital (professional status) had played a positive role in their integration in their neighbourhoods. A similar observation was made by Rogaly and Taylor (2007, 67) who stated that the Filipino nurses in their research talked about being taunted by white boys in an area where they had recently moved. The strategy that they employed to create physical safety for themselves was to make sure their nursing uniforms were visible, as this symbolic professional identity engendered more value and respect. In addition, Allen (1971) argues that socioeconomic factors play a large part in mediating prejudice based on colour and assimilation of professional Asian people, in terms of speech, dress, ways of living, and expectations for themselves and for their children, affording them a higher level of acceptance by the majority. I shall discuss this aspect further in the identities section.

Two of the interviewees of Pakistani origin described their integration in the context of inter-marriage with English partners. The following account shows how a predisposition to the British way of life is played out on the ground:

*Well, you see I feel as though as I always belonged to Britain, we read about Britain so much and our forefathers had worked with the British, our parents always said good things about the British, they are friendly and honest people,*
who don’t back bite and respect you for who you are. I have never encountered any bad experiences and I have lived in here for 49 years. I have two daughters, you see they are married to local lads, I mean English boys, who are very nice, we are all happy here (gp4b).

The above account touches on many issues. It is often assumed that the relationships of post-colonial people to Britain commenced only at the point when they or their ancestors embarked on their journeys to Britain, failing to take into account their exposure and conditioning to the British way of life, under colonial rule (Sayyid, 2004). It is a well established fact that the colonial relationship was based on exploitation, as coercion and force were often involved in the creation of the social order (Brah, 1985). However, there is also ongoing controversy over certain aspects of colonial links which are evidenced in the interviewee’s account where it reflected upon on in a positive way. On an individual level, people may well have benefitted from colonial rule, for example, through the introduction of meritocratic procedures and middle class social structures.

Song (2009) is critical of the assumed relationship between intermarriage and integration and argues that though intermarriage can entail the transcending of racial, ethnic and religious boundaries, considering them as good indicators of integration, and assuming that social distances are lessened between the minority and majority white groups is problematic as such a phenomenon is both more tenuous and complex than envisaged. In relation to residential integration or segregation, the author refers to a study by Caballero et al. (2008) which found that mixed couples in Britain do not always live in multicultural areas. The perception of integration may be based on the loss of the minority spouse’s ethnic minority identity as researchers use the term synonymously with the term ‘assimilation’. In addition, cultural assimilation does not mean structural assimilation. Minority individuals who have intermarried cannot be assumed to be immune from the racism of the wider family network or the wider society and may not feel welcomed or experience a sense of ‘belonging’ that in many mainstream settings. Assumptions are made.
on the basis of a linear model of assimilation which suggests that the offspring of a ‘mixed race’ couple will have a diluted sense of the minority parent’s ethnicity and culture. Song reminds us that such assumptions may overlook the re-emergence of the ‘melting-pot’ theory that was based on the notion whereby a minority person will eventually fully integrate into white society.

Regarding the residential patterns of professional groups of Asian origin, Allen (1971, 34) contends that such group did not form separate geographical or social units like their low skilled/unskilled counterparts did. However, the accounts of several interviewees in all three areas indicate that there may have been residential clustering among the overseas-trained South Asian doctors while living in predominantly upper middle class areas.

Allen (1971) argues that migrations of all kind involve stress for migrants as it involves new circumstances in the form of social organisation; hence migrants tend to re-create familiar patterns of life by preserving ‘customary social relationships’ in whatever small capacity they can. Individuals draw not only security from such relationships, both socially and economically, but they also form part of individuals’ self-identification. In all three areas where community interaction with white members of the community was described, it was, interestingly, mostly with individuals with a lower middle class/working class background and interactions with upper middle class white professionals were rarely mentioned.

In Manchester, the doctors talked more about life with other Asian families than their counterparts did in Barnsley and Sheffield:

> Asian families want to move upwards but also would like to have a few Asian families in the area, they feel secure that way (gp1m).
The interviewees in Manchester and Sheffield talked about navigating much wider city spaces than in Barnsley. This may be related to such contexts being receptive to BME communities:

*My social interaction mostly was with our own doctors, Pakistani and Indian; I was friendly with many white doctors because in my neighbouring area all other doctors were white. We used to visit each other [he mentions a couple of Asian names]. There were around 30 Asian doctors in the mid 70s but when I took up the practice, there were only two or three. I’ve had good relationships, used to meet each other socially, used to organise social programmes, used to go on picnics together with wives and children (gp9s).*

His account shows that though the doctors lived in white middle class areas, their contact was mainly with people from similar a race and class background. The interviewees described their areas as being well served in terms of meeting the cultural/religious needs of the Asian community in general. Barnsley, however, does not appear to cater for the cultural needs of its small sized Asian community, and Asian supermarkets have not found their way into the area as yet. All the interviewees mentioned travelling long distances to neighbouring cities to access relevant facilities, and their comfortable socio-economic status allowed them to combat cultural isolation (Chakraborti and Garland, 2004).

### 7.3.4 Place Integration

The interviewees’ integration in Barnsley can best be explained using a practical model developed by Cutchin (1997, 25) for rural physician retention. The author uses the term ‘experiential place integration’ which places its focus on the connection and interaction between doctors and local communities. The author uses the above concept to determine how strongly a GP feels part of the community, and the degree of integration with the local community, and argues that it is this degree of integration that influences their retention in rural places. Cutchin’s practical model proposes three primary principles: security,
freedom and identity which characterise place integration. The enhancement of such dimensions determines how well a doctor has integrated and feels a sense of place.

Cutchin’s dimension of security includes: confidence in medical abilities, commitment to aspirations and goals, ability to meet family needs, comfort with the medical community and institutions, practice group environment, availability of social and cultural networks and the respect of the medical community and community at large.

Having worked both in the country of origin and in UK hospitals, all the interviewees talked about their confidence in their medical abilities based on several years of hands on experience related to the specific diseases suffered by their local communities such as chronic chest diseases. The fact that majority of hospital doctors were also of Asian origin and part of the professional diasporic community, referred to by many of the interviewees, meant that they were well networked with each other. The interviewees’ accounts show that their ethnic links proved highly significant when making arrangements with other overseas-trained South Asian doctors for undertaking Out of Hours Service. The spaces such as the Rotary Club, The Lions Club, as well as golf and tennis clubs, became spaces of elite networks that worked to connect interviewees with place and the medical community at-large. The leisure pursuits combined sport with socialising activities, developing social and cultural capital (Valentine, 2001). The following interviewee’s account shows how Asian food and hospitality also played its part in forging diasporic solidarity assisting in the integration process (Lakha and Stevenson, 2001):

*It was mainly Asian doctors when my husband joined the ‘Rotary Club’ with a few white doctors, they used to come and enjoy the meals that we cooked on a rota basis and spent some time together, ‘Rotary’ was a good thing for mixing (gp1b).*

Cutchin argues that the interaction between physician and the physical environment of a place presents challenges and responses and within such processes lie the act of
integration. Cutchin adds that the physician becomes woven into the social fabric of the place through interacting, over time, with the evolving problems that a place poses. The following account shows how specific contextual embedding was achieved by one of the doctors in the study:

There was a lot of community activities that I and other Asian doctors used to go to, there might be a dance, there might have been a pea and pie, whatever, small things, you know. I have a reasonably high profile in the community; I have served as a local councillor, well, this MBE was given to me by recommendation by my patients who are 99.9% white... for my services in medicine. I am involved in charity work, there is the ‘Lions club’21. We hold functions and raise funds for local charity, you know, local causes, e.g. if someone needs a wheelchair in the community and they can’t afford it, we buy little things or whatever it takes from the funds. I have been its member for 37 years and have raised several hundred thousand pounds in the past for hospitals and things, that’s my contribution to the community (gp2).

The above account shows the interaction of an overseas-trained South Asian doctor with low and high class strata that includes participation in community activities such as dancing, and pea and pie parties, which specifically relate to the culture of a working class mining community. The evidence also shows how elites’ own privileged position may have enabled them to integrate all sections of the society with ease.

The membership of the Lions club referred in the above account can be regarded as class membership which cannot be gained solely by one’s job, but rather is a way of ‘mimicing’ a culture of that class which dictates its terms as stated by Bhaba (1994) in his theory of mimicry. The findings also support Lahiri’s (2000) assertion that the mimicry theory can also be reworked in specific contexts such as how a middle class Indian student attempted to take on a white working class identity in order to be accepted.

21 The Lions club is a charity organisation that serves the needs of local and global communities. Its ethos is that working together can initiate and carry out projects that will make community a better place. http://www.lionsclubs.org/EN/our-work/index.php
It would appear from the interviewees’ accounts that their interactions with the sub-sets of pluralist British society reflected both Bhaba’s and Lahiri’s approaches.

The combination of place and person influences the integration process and leads to variation within the integration experiences (Cutchin, 1997). The interviewees’ accounts show that their own characteristics such as exposure to western education in the countries of origin, professional status, and the specific characteristics of the place such as rural context and its need to sustain healthcare provision, may have facilitated the integration process.

The challenges of working in rural practices included dealing with complex chronic diseases as most of the patient population was described as ex-coalminers. The interviewees’ accounts show sensitivity and empathy to the social context and realities of the majority of white working class patients as they described how the occupation of mineworkers affected the life chances of those patients, and the ensuing demands placed on the doctors. It appears that the ethnicity of the doctors was also a resource here as many talked about the usefulness of their expertise gained in the country of origin:

They [the miners] would invite us, just to get an idea of how people are working inside mines... sometimes they had to really, you know, crawl through small places,[pause]people were getting more neck pain, sickness, chronic chest diseases, fortunately most of us[Asian doctors] had ample experiences of those illnesses from our own countries(gp1s).

The empathy described in several of the interviewees’ accounts towards the miners’ circumstances shows they were aware of the significance of engaging with the social contexts of their patients:

I was aware that paperwork needed to be completed there and then. I mean like any compensation because people with mines... there were lots of people with pneumoconiosis [lung disease acquired in mines] and for
pneumoconiosis, they had to give compensation, people were suffering a lot really. We had to write letters in a particular way and as quickly as possible. Sometimes you have to do more details... he [patient] cannot breathe properly, he’s out of breath like that he needs medication, and again these are those things because they were really working very hard, and in very adverse circumstances, you know they have to be inside long time, and they were getting this disease because of the... mine dust (gp1s).

Ability and opportunity to achieve a vision and develop something of their own in the form of providing enhanced primary care services, and reducing the cost of secondary and tertiary care, was seen as offering the freedom to practice holistic medicine and continuity of care by many interviewees. Two of the female interviewees talked about focusing on offering enhanced primary care services for pregnant women and their newborn babies, services that did not previously exist. They were proud of their achievements as previously, female patients had had to travel long distances to attend hospital ante-natal appointments whereas these services were brought to their doorsteps, as a result of the doctor’s entrepreneurship activities, as previously discussed.

Networking with local people on an individual level was instrumental and a reciprocal relationship appears to have existed in several of the interviewees’ accounts. For example, one interviewee described how networking with a local woman, a retired tax officer, helped him become familiar with tax affairs, another one mentioned how an ex-senior council manager, who subsequently worked for him, expanded his local links. Female interviewees talked about networking with local women for child care arrangements. Such relationships appeared deeper and warmer than simply instances of networking:

I came to know this lady, through my hospital clinics you see and so she was quite willing to do the full time nanny post, she was not a professional you know in those days, just a word of mouth, you know you. I got on well and she got on well and that’s it and she was in the age group, like a grandma to the children, so everything fitted fine (gp1b).
In relation to the ‘dimensions of freedom’ in Cutchin’s model of place identity, the interviewees talked about the freedom to practice holistic medicine and continuity of care, being able to socially interact, the ability to develop healthcare provision, become involved in community affairs, personal and family activities, and developing perspective on self and place. In relation to the dimensions of identity, interviewees talked about being able to work with like minded practice groups (often with other overseas-trained South Asian doctors), being able to fulfill aspirations in place, (for example, being able to access government funds to modernise practice buildings) being able to see themselves as belonging to communities.

At the time of arrival, having an awareness of self in time and place, relating to the identity dimension of the integration model, the interviewees described experiencing a feeling of social isolation. Ethnic minority households in a rural context do not privilege notions of ‘community’ because of the small population and their spatial distribution (De Lima, 2004). There was evidence of the duality of roles in the interviewees’ accounts, that is, healthcare professionals as well as becoming community leaders advocating for the needs of the Asian communities in Barnsley. The interviewees described how they maintained self-esteem and a sense of identity. While some interviewees talked about directly integrating with the local communities, others talked about getting involved in community development activities in order to engage with rural minority ethnic groups and their maintain cultural identities. The majority of the interviewees, both of Pakistani and Indian origin, described their political mobilisation in seeking to set up a legitimate place in a public space for the provision of their specific cultural needs (Vertovec, 1997). This resulted in the emergence of the Barnsley Black and Ethnic Minority Initiative (BBEMI) in the 1980s. The aim of the organisation was to raise local people’s awareness of diversity issues as well as tackle the social isolation experienced by BME communities. The interviewees’ accounts provide evidence of intra-group cohesion among the interviewees
of both Pakistani and Indian origins, in relation to joint working and creation of a collective space for the Asian community - this may be due to the communities being very small making collective action the only viable action.

In addition, interviewees of Pakistani origin also talked about their involvement with charitable work, managing to raise sufficient funds to purchase a building for the use of a local mosque, congregational prayers being considered an important element of their religion. The interviewees adhering to the Hindu religion talked about worship as a private matter rather than collective, which may also be related to the difference in both religions and within religions, for example, temples based on caste, regions, background and settlement history (Vertovec, 2000) or where the differences between them have their origins in language and nationality (Bilimoria, 1996).

Cuba and Hummon (1993a) contend that place identity concerns significant affiliation of self with place, using in their study, an eight dimension conceptual framework for measurement of such affiliations, including the following responses in an area: friend-related (people, neighbours) dwelling-related (home ownership, personal possessions), self-related (feeling comfortable), family-related (reared family in the place, work), amenity-related (natural environment), community-related (sense of community), and prior experience-related. Many of the interviewees’ affiliation in Barnsley appears to be rooted in economic and status relations so can also be described as friend-related and family related. as evidenced below:

Barnsley has been my home for the last 37 years, my attachment is basically with the place because it gave me my living. The attachment is mainly to the family not to the place, but to the place my attachment is because it gave me my daily bread. You can go anywhere and its fine but if you have never even been anywhere ‘there is pie in the sky’. You can go to London to live, but what’s the point if there is no work, we all may have dreams but that’s not the
reality. This place has given me as I say, my daily bread. I have been happy, I have been recognised, what else more can I ask for? (gp2b).

The interviewee makes nostalgic comments about working in London as many of the doctors previously mentioned they came to the UK thinking that they would work in prestigious hospitals in the capital; however, he is respectful of the place he has worked in for nearly four decades for it has provided him with his livelihood. It is noteworthy that the interviewee uses English idioms such as pie in the sky and gave me my daily bread; the latter comes from the Lord's Prayer.

The interviewees in Barnsley were more likely to talk about national attachments than local; for example, one female interviewee talked about her regular trips to the Chelsea flower show and Royal Ascot, as well as visiting her network of friends up and down the country. Others also referred to place as a context that provided a secure base from where they could interact with the wider world. A common expression that was used by many interviewees was ‘this place provided us with a space to grow’. Much of the social participation tended to be in neighbouring cities and towns where people from similar backgrounds lived. The fact that the interviewees do not refer to an extensive involvement in the local community is not necessarily related to a desire not to integrate; rather, this should be seen as the product of the wider social context in Barnsley which does not reflect the multicultural aspect of Britain in the interviewees’ everyday lives.

Place was experienced differently in Sheffield. The interviewees’ accounts show that their involvement in local communities was with a much wider range of activities than in Barnsley. This included being involved in a local school mentoring project, equality work with the Community Relations Council, working closely with the police regarding community relations, membership of Rotary and sports clubs and other things in the community. The interviewees also talked about being directly asked by white patients to
participate in community activities, for example, involvement in boxing matches as a doctor, boxing being a local working class sport.

Since the majority of Asian people in Sheffield migrated to work in the city’s industry, their education level was likely to be not so high. This meant that people like the overseas-trained South Asian doctors were in demand when it came to representation at an institutional level. The interviewee (of Indian origin, Hindu) quoted below, explains how he happened to become a representative for the minority ethnic community:

I have been involved in community cohesion for the past 25 years; I’m respected as one of the persons who has done that. I used to join all these... African-Caribbean’s and others, the Pakistani community. There was the Living Art from India, Indira Ghandi and Margaret Thatcher, they called few artists from there, painters, decorators, sculptures etc, I think it was ’82 in the Millennium Art Gallery, there I was [link] the person, my wife was a voluntary English teacher, and the woman that worked with her... her husband was the curator of Millennium Art Gallery, so that’s how we met, he said ‘look I don’t know anybody involved in the Indian community, so you can lead that part’, and link up with the Indian High commissioner etc, so, we organised that. After that we had a cultural programme as well, that was an exhibition I think for two weeks, the artists came and did the casts there (gp5s).

He adds how one contact led to the other and he became embedded in local structures,

...so then somebody called me ‘Look there is no Indian organisation, there is nobody like you, I thought you are the person who can do it’, then I was involved in the community. So from the beginning, I was involved in the general cohesion work, so first approach was from there, so I represented everybody at that level, I was closely working with the Chief Constable on race equality matters for many years and represented on the local Race Equality Council (gp5s).

Several of the interviewees talked about local iconic buildings such as the Millennium Art Gallery and local people that they could relate to, and feel included. There was also
evidence of cohesion within the South Asian community, for example, the interviewees of both Hindu and Muslim origin described how they pooled their resources to make charitable donations to Pakistan during the earthquake crisis. The interviewees in Sheffield were much more explicit about their concerns as to how they may be judged by their patients, than were the interviewees in Barnsley. The former group was constantly striving to improve their image as they also had to deal with the competitive nature of urban GP practices.

The Manchester interviewees’ accounts suggest there was more intra-group cohesion here than in Sheffield and Barnsley, as most interviewees described their social interaction with people of a similar cultural and linguistic background. This may be related to the fact that the city of Manchester provided the context for such opportunities, bearing in mind that the Asian community is much larger in size than in Manchester than in the other case study areas. The interviewees mentioned being involved in literary events (Mushairas22), and interacting with lay members of the Asian community, though mostly also with other elites.

McPherson et al. (2001) argue that people choose who they wish to associate with, and often such preferences are based on cultural similarities and the sharing of origins, customs and values that brings better understanding for people. Kalmijn (1998) argues that apart from cultural compatibility, people also choose to interact with others who are as socio-economically successful as themselves, the implication being the subsequent sharing of similar activities and social circles. However, Martinović (2013) adds that the determination of such choices is only one element of the story, as the context in which individuals are located also dictates the extent of contact with others of preferred characteristics, for example the opportunity for inter-ethnic contact is determined by the size of one’s own ethnic and other groups, also how segregated/integrated the ethnic group

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22 Mushaira is an Urdu word for a poetic symposium where poets gather to perform their works and is a much-loved elite cultural activity in Pakistan and India.
is in the area (Blau and Schwartz, 1984). Martinović (2013) adds that ethnic groups that are bigger and more segregated provide greater opportunities for intra-ethnic contact whereas smaller groups that are spatially dispersed are more likely to have inter-group encounters.

For a community identity, social participation in the local community is essential (Cuba and Hummon, 1993b). However, the interviewees from the Manchester area focused less on social participation in the local community and more on their involvement in the business of professional bodies such as the Local Medical Committee (LMC) and BMA. Rotary clubs did not surface in any of the conversations with interviewees from Manchester. Less social participation may be related to the fact that these roles were being taken care of by other members of the Asian community as the city has a much larger Asian community when compared to Barnsley and Sheffield.

In addition, almost all the interviewees talked about their elite networks based on alumni relationships and how they maintained close contact with their friends and colleagues, meeting up annually as a group where information was exchanged. Interviewees across all case study areas talked about sending remittances for charitable work to the country of origin, however, four of the Manchester interviews talked about their extensive involvement in social entrepreneurship activities in the countries of origin showing that the concept of community is much wider for this cohort which transcending national borders. Some of the interviewees mentioned that they did not wish to be pigeon-holed and work solely with their own community and actively sought out areas which provided wider opportunities. There was evidence of political activism in some of the interviewees’ accounts. One interviewee stated that his concern for the care of elderly people had led him to be invited by the Labour Party to be part of their working party on these issues. He talked about receiving recognition for his services in medicine in the form of an OBE and being nominated for the GP of the Year which provides evidence of elite networking. He
described his heavy involvement in local politics as well as political issues in the countries of origin and the fact he is a regular writer for local and national newspapers. These issues will be further discussed later.

7.3.5 Doctor-Patient Interaction

In this section, I will discuss evidence relating to the perceptions of the doctors in the study of their doctor-patient interaction which shows that different elements of both the doctors’ and the patients’ identities intersected in different contexts producing unique experiences.

The findings show that the standard theories concerning socio-cultural dimension of western medicine do not reflect the experiences of overseas-trained South Asian general doctor. For example, Lupton (2012) refers to asymmetrical relationships in the clinical discourse where powerful groups in possession of medical and scientific knowledge have been privileged over others. The interviewees’ accounts in this section show that such asymmetry is reversed when this encounter is between a white patient and an overseas-trained South Asian general practitioner as both bring an imperial element in the encounter in the UK context. The doctors’ accounts show a variation in the experiences of the doctor-patient relationship. There appeared to be a stronger doctor-patient relationship in Barnsley than in Sheffield and Manchester even though the context of Barnsley was less reflective of the doctors’ cultural identities. One interviewee described his patients as part of an extended family whereas others talked about having a strong bond with their patients.

Emphasis was placed on respect by several of the interviewees:

*My view is that you will only give me respect if I give you respect. I don’t think many people will come here and abuse me. When people know you, they look on you differently, It’s like when this patient came the other day and said, I saw an Indian doctor in hospital, he forgets that I am an Indian doctor too, do you see what I mean, they believe that I am part of them.. You see, in the same way, I see them as my extended family. The proof is in doing your job right, if you do that, they respect you for that (gp2b).*
The following interviewee’s account suggests that learning occurred on the part of both doctor and patient:

When I came I couldn’t understand the dialect, because in the hospital surroundings it is different, whereas in general practice, they just, they use their own dialect you see, I found it difficult.. I couldn’t understand, so I had to get my receptionist to come and tell me what they were on about (laughs), particularly ‘tatoes’, this gentleman would say that... ‘tatoes’... potatoes... (laughs), he was going on saying... They could follow me but it is the bounce with dialect you see., it is not too bad now, it used to be quite strong the Barnsley accent, at that time in the 70s (gp1b).

It would appear from the above account that such experiences contributed towards breaking the ice and the doctor and patient getting to know one another; these encounters were likely to have been instrumental in dismantling the power hierarchy which existed due to the dynamics of race, class and doctor-patient status. The fact that many interviewees experienced geographical isolation in rural areas where they had no immediate family or even community members may have created a need for the south Asian doctors to have a strong bond with their patients.

The integration of cultural values on a conscious and unconscious level was apparent in many of the interviewees’ accounts which helped build trust with white patients:

When I see the patients on the streets, they always tell me how much they appreciate the service. When I stop and talk to them, I know most of them and I always ask how is your son, your daughter etc, I do this as an Indian because family values are ingrained in us as you know, we are so used to asking about mama, chacha, baba, (uncle, old man) you know, I didn’t realise they would appreciate it so much, they feel good about it that I take an interest in them and their families, and that they appreciate it very much. Once I asked a patient, ‘How is your dog with spots?’ she said ‘Oh the dog died a while ago, but you have a good memory, doctor (gp1m).
He goes on to explain that through his interactions he learnt that white working class family values were not so dissimilar to his own cultural values:

*I sometimes find similarities between white working class family values and our culture, our experiences, they care and support for their families sometimes in the same way as we do. They appreciate it when I ask them about their extended family, there is class distinction here, and a vast majority of doctors in this country tend to be from the upper middle class, and I am not sure if a middle class doctor from here would take an interest in what his/her [patient] family are up to. These little things go a long way to build a trusting relationship between me and my patients and trust is so important in our doctor-patient relationship (gp1m).*

Evidence shows that the elite professionals incorporated their religious/spiritual beliefs in their practice. For example, the following interviewee states:

*I found myself often working with poor people for whom sometimes I could do little as a doctor to change their social circumstances. But I remember what one of our poets had once said that ‘Dard ke dawa na sehei, dard sun he liya hota’, [if you cannot cure pain, at least you could have just listened to it], so there was a lot of that. I could relate to some of the things, coming from Kashmir, where I had seen deprivation and poverty directly in the communities that I had worked with (gp8s).*

The doctor-patient relationship in Sheffield and Manchester was described as more of a mixed nature. Working with marginalised communities both white and Asian as marginalised practitioners and the challenges it brought out were mentioned by several of the interviewees:

*The English patients that we had were actually the ones no ‘local’ doctors wanted to keep as these patients were very demanding (gpm1).*

Another interviewee stated in detail the challenges involved:

*I started [the] practice single handed; I used to write to my patients and telephone them to remind them about immunisation for their children as the*
children should have had their immunisation. The drawback for us was that we did not get paid if the children did not have their vaccination. So, I used to visit around eight to ten patients daily in the evenings. The ones who agreed, I used to give injections to them in their own homes as they did not attend the surgery (gpm5).

The interviewee described in detail how one young 18-19 years old white mother had missed three immunisation appointments for her baby but he managed to track her down after several home visits. His account below provides evidence of the vulnerability of migrant doctors trying to provide a service to socially excluded communities:

By the time I managed to get round to her, it was late evening. She said the child was asleep. I said, it will not harm the child, it’s just a prick and that the child will go back to sleep again. She agreed and I gave the injection. After a while, she made a complaint to the PCT that I went to her house late evening. PCT did not pay any attention to the fact that I had gone to give an injection. They took a different view. They said that the woman was young and was not ill, why did you go to her house? I had to collect all the evidence of my whereabouts on that day and how many patients I gave injections and how I had left her a note earlier that I would call back etc. It took about three to four months and I had to appear before our medical committee (gpm5).

He adds that the structures were less supportive than patients and that it was the intervention of a lay person, the girl’s mother who eventually saved his name:

Her mother found out that she had reported me to the PCT, her own mother said to her that she must withdraw the complaint, otherwise she will break her [daughter’s] legs. ‘He only came to give your child an injection, what else did he do?’ The daughter said, ‘He came at night time’, the mother said, ‘so what? he only came to give an injection to your child’. The mother said, ‘Did you not ask him to visit you at 2am when you were in a refuge?’ I did have to talk to her mother at the time as she [the daughter] was half dressed [when I visited her] which I did not like and had to tell her mother that she should behave properly if she would like a doctor to visit her; the mother had told her off then
as well. She withdrew her complaint and the PCT dropped the case against me (gpm5).

His account below provides evidence of a possible shift in individuals’ attitudes:

The same young woman wrote to me one year before my retirement and said, doctor, my children have grown older now, I have matured, my mother has died, I have not received the kind of service that you provided me, I want to come back to your surgery and be your patient, will you accept me?(gpm5).

The above story of a young woman who came to appreciate the services for which her mother saw the value from the start may be related to her maturity as well as evidence of how the presence and perseverance of overseas-trained south Asian doctors may have contributed towards the transformation of attitudes in UK society.

The accounts of the doctors in the study show that the nature of doctor-patient encounters had been shaped by the historical colonial context:

...some would show their arrogance by their body language that they were superior than us. You see they feel superior because they have ruled over you for hundreds of years or more, you know, they feel they are superior than all over the world not just us, they have colonised every part of the world. We did not think of the white working class as coming from lower strata because before us, they were English first (gp10s).

Another interviewee’s account points to the social hierarchies that exist within the UK social class system. He adds that being migrant doctors, their focus was on performing their duty well:

We had no concept of demanding/non-demanding patients, we saw ourselves as the provider of the service and that we had to do our duty. These patients were very appreciative of our services and they had a lot of respect for us. In fact we often used to give their examples to our own community patients who were sometimes yelling for more help and we used to say, look at these patients who are so content with so little etc. These English patients were
rejected by others but for us they were still better than our own in terms of their demands (gp5m).

The above account refers to a number of issues such as the incorporation of cultural values which emphasise a sense of duty and the issues of working in deprived areas where patients are classified as demanding. The experiences of the marginalisation of overseas-trained South Asian doctors within the NHS may have better equipped them to empathise with patients from disadvantaged backgrounds and their accounts provide evidence of insight into the symbiotic relationships that occur between marginalised practitioner and marginalised patients.

The account below would suggest that due to the perseverance of overseas trained south Asian doctors, marginalised white working class patients may have been the beneficiaries:

At that time, if you were not happy with a patient, you simply wrote a letter for the patient stating that you were not happy to continue providing a service for them and then they had to find another one from the NHS list. I remember some patients used to say that they did not have a problem with me, why was I de-registering them, so I didn’t in the end, and they were the ones who stayed in my surgery until I retired and were forever grateful for the service they received (gpm5).

Interviewees talked about the diverse healthcare needs of their patients and the demands placed on the Asian doctors. In ethnically dense areas such as Manchester and Sheffield, the interviewees’ accounts appeared less sympathetic to the issues confronting the South Asian patients which may be related to the complexity of their healthcare needs:

They[the English] used to come with complaints like, doctor, I have a headache since yesterday, so I did certain checks, checked blood pressure, checked temperature and mouth. With Asian patients, it was like this, doctor, I have severe headache, and my ear aches as well. Ok, I check for this. Then I am told, oh, my foot hurts and I cannot walk, I have a boil on it, so I examine this. And then I am told, I have stomachache, so we were asked to write 3-4
medicines on one prescription. It took us longer that way as we had to explain things. Then I used to be told, oh doctor, I have had a letter from my sister, can you please read it and reply to it accordingly. In comparison with the English patients, we had to spend much more time with our own [Asian] patients (gpm5).

The interviewees stated that being part of the same cultural group as the patient was both a benefit and a hindrance:

_The Asian patients, when they do have appointment, instead of one patient; you get four because they want to see me. I think communication is crucial and patients find it very satisfying when they find that I can communicate with them. When I go to visit other GP surgeries and in some English doctors’ surgeries, there is a notice placed, one patient, one complaint, one appointment, one patient. When I have Asian patient before me, I cannot say to them just one complaint or one person (gp1m)._

Ahmad et al. (1991) also found a prevalence of less favourable attitudes among Asian doctors towards Asian patients. This may relate to a number of issues. Ethnic inequalities in health and health care is an area which has been well researched (Bhopal, 2008; McAvoiy and Donaldson, 1990). Meeting the linguistic and cultural needs of such patients in deprived locales must place a disproportionate burden on overseas-trained south Asian doctors. Scaife et al. (2000) argued that South Asian patients are more likely to be frequent attendees at a GP practice. The Asian patients may simultaneously regard Asian doctors as a member of their own community and may make unrealistic demands. The Asian doctors on the other hand may not have wanted to be pigeon-holed in the roles that were ascribed to them, that is, to work with pre-dominantly Asian patients, as some interviewees stated earlier. The difference in class identity of overseas-trained south Asian doctors and Asian patients may have acted as an additional barrier.

Interviewees in Manchester talked about the ever changing demography of inner city practices, and meeting the needs and expectations of diverse communities such as Irish,
Chinese, Polish and Nigerian. They described the transient nature of the population in an inner city practice. It is interesting to note that the interviewee refers to the new migrants as an ‘influx’, taking on dominant societal values:

*When I started we never had any of this err we now lot of immigration from err Nigeria, Romania, Poland, Czechoslovakia and from Pakistan too, there was a lot of influx in between err year 2002 to 2006 a lot of people came, we have got even people from Africa... sub-Saharan Africa, there is lot of migration even Portugal, there is lot of influx even a lot of people from France, they are sub-Saharan Africans, they are migrating, then we have got Somalis (gpm7).*

Evidence of perceptions of the doctors in the study of their doctor-patient interaction shows that different elements of both the doctors’ and the patients’ identities intersected in different contexts producing unique experiences. The findings of this study show that standard theories concerning the socio-cultural dimension of western medicine do not fully reflect the experiences of overseas-trained South Asian GPs. This is because the asymmetry in power relationships in clinical discourse is reversed in their interactions with white patients, since both bring an imperial element to the encounter. The narratives show how the interviewees constructed their own identities in relation to their perception of white identities, which they experienced differently in different geographical and class contexts. The marginalised positions of both overseas-trained South Asian doctors and white patients led to the forming of symbiotic relationships, insights of which show that they are more of a reciprocal nature than fuelled by medical dominance.

**7.3.6 Experiences of Racism and Coping Strategies of Elites**

This section explores the interviewees’ own perceptions and experiences of racism, as well as those of other overseas-trained South Asian doctors. The interviewees were asked whether they had ever experienced any overt or covert instances of racism. Examples of
what constitutes racial harassment were adapted from Collins (2001, 171) in *Racism in Medicine* (Appendix 2).

Initial responses were interesting as almost all the doctors in the study denied experiencing overt or covert racism and appeared to believe that racism did not impact on the doctor-patient relationship. Their responses seem to fit in with what Beagan (2003, 612) refers to ‘professional socialisation’ which aims to produce neutral doctors for neutral patients with a belief that one must, as a standard of clinical practice, treat everyone neutrally, and objectively, as if they were cultureless, classless, raceless and genderless. Denial may well also be related to the high level of confidence that they possessed and their middle class status (Shaw, 2010). This belief of social neutrality was challenged by the sharing of my own experiences as a social worker which allowed the interviewees to open up.

In Barnsley, a common belief among the interviewees was that professional identities mediated ethnic identities and that the low level ethnic density was also a protecting factor:

*We had a lot of respect here because we were professionals; the patients had a lot of respect for us. I think this will happen where you have more Asian community, here in Barnsley; it was only the Asian doctors here. They [public at large] did not see us as threats in the same way that they will if it was someone for example a general public person from the Asian community (gp6b).*

Many of the interviewees’ accounts suggested that professional identity predominates when the area has no minority population. Ethnicity in such contexts also created social capital mitigating the hostility that many black people may otherwise be subjected to:

*In the village the community is very close-knit. The only non-white persons in Barnsley in the 1960s were Asian doctors and if the locals saw you in that time, they will think that you are a doctor and would respect you (gp3b).*

The interviewees’ own analysis as to what encourages the development of prejudice was the competition for welfare resources in ethnically dense areas, such as housing,
employment, healthcare, education, benefits, a view also supported by Bonnett (2000, 132) who refers to ‘white backlash’ against multiculturalism. Vaughan and Robinson (1986) refers to the responses of middle and working class white people to immigrants. Here, the former ensured that the pre-existing colonial relationship with Asians was maintained and demanded cheap labour while offering little social acceptance or resources, while the latter perceived immigrants as direct threats on their identity. The white working class was forced into situations where they had to share jobs, houses, neighbourhoods, schools, and other scarce resources with immigrants whom they had been told to regard as inferiors. The white working class, as a result, engaged in exclusionary closure to both the middle class and immigrants. Exclusion towards immigrants took the form of prejudice and discrimination. Tyler (2012), in her ethnographical study, explores the entwining of discourses of race, class and coloniality within Leicester, a multicultural city and a suburban English village in the countryside of Leicestershire. The author asserts in her study that white working class people were able to make distinctions between non-respectable other white racists and Asian doctors whom they perceived as respectable British Asians. The following account would suggest that though not directly subjected to racism, these experiences took place within earshot:

*I think, odd ones sometimes do, you know, people say you are a Paki and you are something but we never had any problems (gp6b).*

Some of the interviewees seemed to have a very simplistic view of what amounted to discrimination. For example, a female interviewee stated:

*Well, I mean once I got the job you see there was no question of discrimination, I mean it’s as simple as that, I mean, I didn’t have it; maybe other people have had it. No it didn’t happen to me (gp4b).*

This apparent lack of awareness of diversity issues may be related to the culture of the NHS at the time when such issues were not actively promoted. The interviewees also
tended to make constant comparisons with their experiences in the country of origin where it was difficult to secure jobs. In her account, the previously cited interviewee had earlier described an incident where she was threatened by a white boyfriend of a female patient, who was adamant that his girlfriend should not be hospitalised even though she was miscarrying a baby. She describes the incident, in which privilege and marginality intersect:

> *It was in the middle of night when I visited this female patient [white]...her boyfriend took a gun out from his pocket...*, I said, ‘What are you doing?’ He said, ‘If you don’t do what I want you to do, I will shoot you.’ I calmed him down, spoke to him, I said, to be on the safe side it would be best if she could be admitted in hospital, but he wasn’t letting her go because his idea was probably who was going to cook him food but when I closed the door I was really quite worried and afraid, at the time, I didn’t know it was a toy gun, I thought it was a real gun.*

She talks about the response of the police:

> *The next day the police went to check and they said the family are in a mess they don’t know what they’re doing, their house is filthy, and then that man showed the policeman what kind of gun it was, it was a toy, I dropped the charges, because you have to work with the same community and it goes against you, the word gets round, you see.*

It appears from her account that the approach she adopted was more of a coping mechanism in a context where there was little acknowledgement of race issues. She was aware that she had to continue working in that community without the police holding her hand, and that *the word gets round, it goes against you* suggests anxiety about possible victimisation. The police in this incident appear to have taken a lenient stance, even though the incident as described above, seemed to be a serious criminal case with aggravating features such as a female public servant being threatened with an offensive weapon (regardless of it being a toy or real gun, the perception of the victim at the time is
paramount), gratuitous degradation of the victim, and the timing of the offence. However, the police’s failure to take any action was not seen as a major issue by the interviewee, which suggests that she may consciously or unconsciously have lower expectations of the police, like many of her counterparts within the Asian community in the UK. It is a well known fact that criminal justice system operates differentially towards racialised groups (Kalra, 2006). This example lends support to Ahmed and Mukherjee’s (2012) argument that privileged South Asians, despite class difference, share not only cultures, religion and languages but also share their sub-ordinate status as colonised subjects with their working class counterparts in Britain. Vaughan and Robinson (1986) emphasises the significance of considering the causes of prejudice in the context of colonialism and the type of social contact it produced with the colonised. John and Rex (1979) also emphasise on adopting an historical approach when analysing such encounters. Lahiri (2000,xii) argues that:

Imperial/colonial relations are no longer located exclusively in the context of a colonial backdrop; Britain also serves as a ‘space of colonial encounters’.

More recently, Tyler (2012) in own ethnographical study argues that older white people have memories of working in colonial institutions which confirm that *relics* from the empire remain dormant in the UK landscape. This was evidenced in the following interviewee’s account when he was taken by surprise to meeting a patient in a remote British city who had visited his home town. He states:

*Many of my patients were ex-service men who had served in India back in the colonial days. I was quite surprised when one of them told me he had been to my home town Mirpur, finally we made some connection. We had a good chat; he told me about our shortcomings, I mean what was wrong with our countries* (gp8b).

Although a definitive interpretation of the conversation described above cannot be made, it can be argued that the fact that the interviewee could only remember the conversation in
that context is a strong indication that of how it happened and that the patient believed the fault lay with the developing countries rather than the process of colonisation.

Two doctors mentioned that they had heard that some Asian doctors had had negative experiences at the hands of patients, and remembered the publicity it attracted and the pressures placed on doctors as a result. It is possible that the interviewees found it difficult to discuss their own experiences and instead talked about colleagues’ experiences. This may be due to a number of things, such as their own denial, discomfort, gender and age issues impacting on the interviewee process, as well as social desirability.

One interviewee talked about the experiences of his neighbour doctor. A common approach when such incidents were described was that emphasis was placed on the wider public being not intentionally bad, and also the doctors’ self distance from such experiences. The interviewee below did not wish to elaborate on his experiences:

*By and large, people are not bad, this is my sum up but some who are, they are very cunning and very clever. I never had any untoward response from patients but you never know what’s inside people’s mind. Others do experience it, my neighbour, a Sikh doctor was put in trouble, he was accused of sexual harassment and was later acquitted after 18 months because it was never there in the first place, another Pakistani doctor had to close down his surgery because of problems (gp8b).*

Experiences of racial prejudice from other professionals and establishments were only mentioned by one out of eight doctors, who explicitly talked about experiencing racial prejudice from a member of staff in the practice. The doctor quoted below explains the differential treatment he and other Asian partners at the practice received at the hands of their own practice manager:

*There were three of us Asians, and one English partner. The English partner was very good, like a father to us, we never had any problems with him but the practice manager [English] was very bad to us all Asians. She would treat us*
badly, sometimes not issuing cheques, like our salary. The pay wasn’t very huge anyway that you couldn’t save for the next month. So, you needed the money and whenever you asked for it, she will say, oh I haven’t got time to do the cheque and here we are suffering because of it. So, we all decided that her behaviour was not reasonable and we sacked her, we had taken advice from the BMA and did it properly, we gave her advance notice etc but she took us to an employment tribunal. In the tribunal, the same representative who was supposed to support us actually supported her (gp6b).

The interviewee’s account would suggest that as a group the Asian doctors were vulnerable and experienced victimisation on the basis of their race. As the perpetrator of the harassment was white, she was supported by institutions such as the trade union and media. Although another interviewee stated that he had had a positive experience from the BMA concerning his pension benefits, the role of the organisation was criticised for its discriminatory practices when it came to supporting its members in race discrimination cases. For example, in 2002, the BMJ\textsuperscript{23} reported that the BMA had to pay £815,000 in damages for indirect racial discrimination. The interviewee describes being subjected to victimisation from the aforementioned complainant in which the media also contributed, however, the good relations that had been built with patients and the community over a lengthy period was sustained:

\begin{quote}
She won her constructive dismissal case, not only that, the newspaper published stories about our practice that we mismanaged the practice etc. She told the press many things which were not true, it was very embarrassing, the real issue got lost and our practice issue became the focus. We were going to sue her because she had spread rumours about our practice and got the media involved; she had to pay back the compensation that she was awarded because she breached her agreement. Fortunately, we had a very good reputation in the community and patients did not take much notice of it (gp6b).
\end{quote}

\begin{flushright}
\textsuperscript{23}BMJ 2002;324:1541.2
\end{flushright}

http://www.bmj.com/content/324/7353
In general, the interviewees in Sheffield were also reluctant to talk about racism. Instead their narratives tended to centre on constructing themselves as successful professionals. The majority were of the opinion that white patients, having made an informed choice to join their practice did not have any negative attitude towards them, however, when probed further, a few could recall some incidents where the ethnicity of the physician did matter. In general, it was often the positive experiences that interviewees described at length.

The realities of working in a rundown urban area in which fear of racism was real were described by several of the interviewees in Manchester and Sheffield:

_I am not conscious of racism usually, but I used to keep some verses from the Quran in my pocket to ward off danger. It was rough areas, drug dealing, prostitution, pimps, domestic violence, child abuse, you name it, it was everything....I once went to visit my Hindu doctor friends in their practice, what did I see? Both husband and wife are hiding under the table because they were being physically attacked by some white drug users (gp2s)._

The above account is interesting in that the interviewee denies being ‘conscious’ of racism, however, his described action is contradictory, as keeping Quranic verses in his pocket as a protective shield is a pre-mediated action. Two other interviewees also mentioned incidents in which they were physically threatened by unknown drug users who had barged into the practice and demanded drugs. These incidents were only casually mentioned and it appeared that the interviewees expected to take these incidents in their stride.

Many of the incidents described often involved people not known to the interviewees and occurred during evening home visits in deprived areas known for criminal activities. The following interviewee refers to the uneasiness of some of his white patients and having faith in God:

_When I was working in the deputising services, because I was Asian, sometimes I sensed that people were worried about the quality of their treatment but it..._
was ok with God’s grace. An example is when a patient had had an attack at home and I had to see them before hospital admission, you could tell by their body language, their eye, their one or two remarks that they were anxious and may be thinking what is he giving me as a treatment, when they felt better with the medicine I had given, they were equally glad and happy as well afterwards (gp9s).

Interviewees also noted that white patients often seemed to have a preference for an Asian doctor:

I noticed that English patients, once they had had an Asian doctor, they were likely to have an Asian doctor even though they had moved areas. On their medical record, you get a history of their GPs and you only see Asian names. I think we gave them better pastoral care, we did not tell them off, we were not patronising, we gave them good service (gp11s).

While the majority of the interviewees when further prompted acknowledged experiences where they may have been subjected to racism, one interviewee was adamant that he had never experienced any racism:

There was no such thing. I did not experience any racism myself, neither had I seen any discrimination nor did I contribute towards racism. I did have some difficulties but I got there, as compared with India and Pakistan, there was different atmosphere, there was all money and there was all officers asking this, asking that and they were catching you on little things (gp8s).

The same interviewee later stated that a white patient had told him off for arriving later than the patient had anticipated and that he had called for a home visit on a trivial matter which did not even need an urgent home visit, in addition the patient had also told him that people like him had taken over their [British people's] jobs. Upon further probing regarding experiences of discrimination, it appeared that he had somewhat internalised racism. The concept of internalised racial oppression means that racial beliefs and stereotypes of the mainstream society shape how individuals think about others of a similar
racial background (Pyke and Dang, 2003). He stated that he had been a president of the local BMA branch and was critical of the role of the Overseas Doctors Association (ODA):

...those things do happen, in a nutshell those things do happen but we must also look in our own graban [means ‘neck’, a common Indian expression meaning examining our own actions], there was ODA, it was their duty to remind them that it’s also your job to be vigilant, to be fair to their job, to uphold the medical profession. I remember I was also framed in a case; all I had to do was that I am sorry, I did it. I was told by someone that I was set up and I should defend my case, I didn’t want to use the race card, I was so ashamed that I was capable of doing what I did, I immediately said I am sorry that I did it (gp8s).

In the above account, his use of language such as ‘framed’ and ‘set up’ would suggest that South Asian doctors may have been targeted, which in itself, would be classed as a racist practice. His criticism of the role of the ODA also evidenced his allegiance to the BMA. The BMA has been openly criticised for lack of support by its black and minority ethnic members in race discrimination cases. For example, in 2002, the BMA were ordered by an employment tribunal to pay £815,000 compensation to an Asian surgeon after the association refused repeated requests to assist him in race discrimination claims (Dyer, 2002).

For the above interviewee to vehemently deny any existence of racism when he was also an ex BMA branch president reflects a tokenistic contribution within the organisation.

There was a tendency among the doctors in the study to search for almost scientific levels of proof for experiences which could be classed as racist in nature. This may be related to their individual coping mechanisms in which their particular professional background and class position may have entwined:

I never experienced racism from anyone. There was one time that a male English patient came to register with the practice, he asked the receptionist
who the doctor was and the receptionist pointed towards me. The patient walked out and said he did not wish to register, and that was that. But I cannot say he was being racist as there could be many reasons as to why he did that, he may want someone that he can relate to in terms of language and culture just as we do. Based on that experience, I think that the patients who were registered in my practice did not hold prejudices as they were free to go elsewhere (gp11s).

Interviewees in Manchester and Sheffield were more likely to talk about negative experiences with local NHS bodies. The following interviewee talks in detail about how a campaign was instigated against several of his colleagues of both Pakistani and Indian origin, in which they were subjected to racial harassment leading to their dismissal:

I know there was a time when they were getting at Asian doctors, most of them were single handed and they got rid of all of them one by one. I can name all of them…all of them were single handed you see, what they used to do was that everything they (PCT) did was done in such a way that you could not put a finger on it. What they will do you see, in the case of Dr W, I know, they sent this girl whose job was to monitor a few things you know and what she was doing basically was trawling through the notes and finding out, he might have done it but he has not recorded it, so these small things, they accumulated the evidence and said you are not competent enough. You are not looking after patients, you should be going and they made a reasonably strong case (gp9s).

He provides detailed information about the case of a friend, whom he had accompanied in such procedures:

When his suspension ended, he came back to his practice; they said to him, look before you take the practice, we want to see you at the FPC offic.. The meeting started, the chief executive went straight into options, he said, Dr Y, I give you two options, one is either you resign now, if you don’t, I have got these 25 cases, while you were away for two months where you have lagged behind. You see, I would say that if you take me to a practice today and ask me to find cases, I will give you 25 cases, you go and see the patient in the middle [emphasis] of the night, you don’t always remember every bit of it in the
morning to write down, ok, yes, you come in the morning and you might even forget the diagnosis (gp9s).

He goes on to explain that the treatment of Asian doctors differed in different eras with similar incidents taking place in different cities:

There was a time when we were desperately needed e.g. I was asked to apply for the job and then came a time that they did not want us, it was because we grew in numbers. Racism exists and you cannot deny that, its present in every stage. But it is often underground and sometimes it erupts like a volcano, it comes to the surface, ok and then it subsides. Within one year, one by one, they got rid of five to six Asian doctors in Sheffield; I know this because I was involved in helping them out. They might have got rid of me too but what happened was one doctor asked me to take him to the GMC; he escaped from there but his health deteriorated and then the poor fellow retired. But after that they (the PCT) slowed down in their vindictive campaign. I got a phone call from a friend in Glasgow, he was experiencing the same thing in the same way at the same time, they got rid of nine Asian doctors who were running single handed practices in one year (gp9s).

His account appears credible for its detailed nature. He mentions the names of individual doctors who experienced enormous difficulties and suspension. The individuals mentioned in his account include both Pakistani and Indian origin GPs, some of them interviewees in this study. However, they did not discuss such issues at length, though their initial reluctance to be interviewed might be related to such negative experiences. The interviewees who had been subjected to such humiliating experiences may have found it difficult to talk to a researcher. One other interviewee also talked about ongoing difficulties with the PCT, while the remaining nine did not mention experiencing any particular problems. Two other interviewees (Indian origin, Hindu) mentioned a disproportionate number of complaints made against Asian doctors going through to the GMC, rather than being dealt with at a local level.
The majority of interviewees in the Greater Manchester area described being subjected to racist experiences while carrying out deputising services where they felt threatened often by the white male partners of patients. Many of the doctors recalled being asked to do home visits for trivial matters. Two of the interviewees also felt that complaints against Asian doctors are sometimes based purely on cultural/linguistic differences rather than poor practice, and they feel disadvantaged when defending themselves, in comparison with white doctors. Cultural identity was also said to be a bonus in some circumstances, as one interviewee explained that he had received preferential treatment from colleagues and patients:

...they very often used to be very appreciative that err doctors from the Indian subcontinent is... is taking so much care and giving them so much more attention and to... to their needs, their... their health needs and so on, in their view more than their own kind (gpm2).

The account below shows that he chose to recall positive experiences rather than dwell on negative ones, and while he acknowledges the experience of racism, he does not see racism as part and parcel of the wider society; rather he presents a clinical diagnosis:

So the question of, in my experience the question of being an, an Asian and getting discriminated by white patients didn’t happen, yes it does happen once or twice, through people with personality problems, but they’re not reflective of white people generally, occasionally, I can’t even think how many... less than two or three times, the converse has happened, erm sometimes when we’ve had locums the, the patients who’ve seen... they were white doctors, and then they will come back within a few days and say I don’t want to see another white doctor ever again, that sort of thing (gpm2).

The interviewees’ responses exposed the discomfort involved in sharing experiences of racism. Their reflections showed that they had to work through several layers such as professionalism and class attitudes. In several of the accounts, reference was made to the
possibility of making one’s own life better, and that hard work will cancel out any negativity, which shows the prevalence of a middle class attitude.

Experiences of racism from colleagues or other professionals have been documented anecdotally by South Asian doctors. For example, Dadabhoy (2001), a second generation South Asian doctor, describes in depth his experiences during his medical training in the UK, doing hospital rounds and his general interaction with the NHS staff, where he was subjected to hostility and intimidation. However, the majority of doctors in this study chose to remain silent; it was a subject either not commented on or described as not problematic by the majority of the interviewees, except the following interviewee who stated:

*I had a good relationship generally speaking with local [English] doctors but I have also felt with some that there was some negative undercurrent, some bias. Some seem fine (gpm8).*

The doctors working in the inner city area practices were more likely to say that they had had occasions in their practices when white patients had specifically asked for a white doctor at reception. Experience of racial harassment in city areas appeared more common for these interviewees.

Interviewees generally talked about lessening visible differences to protect themselves from the racism arising out of cultural difference. The interviewee quoted below appeared to think that effective communication mediates any other negative attitude, even though he previously talked about experiencing racism when undertaking deputising services:

*No racism. I don’t think, as a doctor, if you can communicate with them, you can talk to them and they can understand what you are saying, you don’t experience much difficulty. Most of my patients are white, they understand what I am saying and I understand what they are saying. If I don’t understand, I say to them, please speak slowly and then I understand (gp1m).*
However, his account below shows the extent of the abuse and pessimism that surrounds such behavior. It also shows that many of the interviewees had suppressed their memory of racist experiences:

*I am not saying that everyone is good; no there are people who will treat you as a Paki, because when your skin colour is brown, this is inevitable, you have to take it in your stride, you can’t change that, they will swear at you. If that happens, I say to them clearly, if you don’t trust me because of the colour of my skin, you are free to join anywhere else (gp1m).*

Perceptions of the key medical organisations differed among interviewees, with one interviewee who is a chair of the BMA stating:

*...me being chair of the BMA, 40% of the GP colleagues here, they are from Indian subcontinent so I have been dealing with them for about 25 years. Very good, as a matter of fact, I have always tried to sort of educate them, that’s fine, we accept it, that racism does play a part, it has a role but your own mistakes, your own short-comings... this been done to me, this has happened to me because I’m Asian, look at it... yes what wrong you have done. Try to rectify that then if something is left there, then we could yes..... broaden your horizon a bit, yes that is there and we will look into it (gpm4).*

The above accounts raise a number of issues. Firstly, they provide conflicting perceptions of experiences of racism. It is possible that some overseas-trained BME doctors may have played the race card, as has been suggested, however, organisations such as the BMA who was accused of discriminatory practices may well appoint like minded people and provide lip service to equality. Without the support of the majority, and appropriate training, BME officers in positions of power may also collude and also act as gatekeepers for the organisation.

Some of the interviewees showed limited understanding of race relations acts and did not have a clear understanding of what constituted racism or racial harassment. The strategy employed by the interviewees in relation to their move from a hospital career to entry into
General Practice appears to correspond to that described by Lykes (1983, 80) as *purposeful indirect coping*, one of the four approaches that black women in her study applied in dealing with racism, which means that individuals respond to the situation deliberately but in such a way that individuals change their goal and acquire solace in a different pursuit rather than solving the original problem. In spite of the fact that most interviewees were able to articulate their experiences of institutional racism on an aggregate level, there were silences in the majority of cases when it came to experiences of racism on a personal level. Some gave brisk replies while others diverted the conversation away immediately and instead gave examples of oppressive practices in the country of origin. Conversations became emotionally charged and the interviewees’ uneasiness was evident. This denial may have been a mode of resistance. Apart from a denial strategy, there was also obvious pessimism around discrimination issues and a common approach whereby racial discrimination is a ‘fact of life’ and nothing can be done to change people’s attitudes. Many of the interviewees were quick to state that discriminatory practices also take place in their communities of origin. The following accounts were typical responses, with an interviewee stating:

*There is no solution for discrimination; I don’t know... what I’d say. In India and Pakistan, if there is a Sanwali [dark] skinned) girl she will have a tough time to get a man. Discrimination is right through, it’s human nature. I mean if you’re going for an interview and one of your relatives comes in, you are bound to be favouring him or her. So as far as discrimination goes, it is human nature, discrimination is an ongoing thing, but on a national level, institutionalised racism etc, that’s wrong. I can’t imagine that there is no discrimination anywhere. It is everywhere (gp5s).*

Another interviewee (Indian origin, Hindu,) also echoed the epidemic nature of racism and the way it permeates all societies:
Discrimination is a story, doesn’t it happen in our own country and don’t people from our country here do it? Pakistani doctors’ practices take Pakistani’s only, or vice versa, that is discrimination too, isn’t it? It is human nature... basically. I think this is where you have to accept that discrimination will always be there, there is a glass ceiling, as in, they will let you get up, but it is possible that they may prevent you from rising further... it is possible(gp2b).

The above interviewee shows his awareness of institutional racism; however, shows little comprehension of how racism impacts on individuals. The growing body of research on stratification by one’s skin colour shows that differentiation by light or dark skin tone is an issue that remains of sociological significance in the lives of black women even today and is described as a lasting imprint of European colonisation and slavery. (Hunter, 2002) argues that beauty is highly racialised, and informed by ideals of white supremacy that dates back to slavery and colonialism. It operates as a tool of white supremacy and patriarchy as it elevates men and whites in importance and status. Hunter refers to her study analysis showing that skin colour continues to affect the major life outcomes of African American and Mexican American women with light skin tone conferring privileges in education and income for both groups as well as a higher spousal status for African American women. Hunter emphasises that it is crucial to examine the intertwined history of the groups at issue in order to make sense of any racialised process.

The following interviewee is able to relate to the institutional racism element, but nevertheless equates his situation and others to ‘beggars’, raising a number of questions, as doctors are far from being beggars, regardless of country context:

...beggars can’t be choosers, simple as that errmm quite a few specialties, not only in General Practice, in hospital sector as well, like Geriatrics, ENT, Psychiatry and those kinds of specialties was manned by people coming from the subcontinent, there is no doubt about that (gpm4).
It is interesting to note that a report in 1996 stated that each recruited overseas doctor saved Britain £28,000.\(^{24}\) Since racism operates in different ways and according to the specific history of a society, (Castles and Miller, 2003) coping strategies can also be culturally specific. There was some ambivalence among the interviewees concerning the impact of colonialism, with some interviewees believing that British society at large is not racist, and others believing that they did not want to fall victim of a self-fulfillment prophesy, so would rather focus on having faith in their own abilities. Social class also played a role in the doctors’ survival strategies as can be evidenced by the following interviewee’s response. This is situated in the class context within which she was raised, with both parents being highly educated:

... if you have confidence in yourself, then you are capable of anything, that’s what I’m trying to say... so our role should be to bring that confidence back and say why not? Because it is in our hands, we are only limited by our thinking... nothing else limits us, if we only think within certain limits then we won’t be able to see beyond that, ...I don’t think that we should adopt the victim role and we should... we are what we are... what we make ourselves (gpm3).

A study conducted by Shorter-Goeden (2004) investigating the coping strategies of African American women when confronted with racism, developed a useful model for coping strategies. It describes the ongoing internal and external strategies that individuals call upon as well as strategies that are conjured jup to deal with specific situations. Ongoing internal strategies include resting on faith, standing on shoulders and valuing oneself. While the first is self-explanatory, the standing on shoulders strategy refers to where individuals place importance on the connection with their heritage, culture and ancestors who had once engaged in emancipatory struggles. Valuing oneself implies

actively engaging in ongoing self-development and providing a positive view to resist the prevailing negative stereotypes.

External ongoing strategy is described as *leaning on shoulders* in which individuals rely on social support, for example, their family. The strategies to deal with specific situations are referred to as *role flexing*, *avoidance* and *standing up and fighting back*. Role flexing relates to altering one’s behaviour such as speech, dress or appearance to fit in better with the dominant group and to minimise the impact of bias and negative stereotypes; this took the form of acting more ‘white’ or appearing less ‘black’. Avoidance strategy implied staying away from places, people, or subject matters likely to prompt biases and prejudices (Shorter-Goorden, 2004).

The evidence that directly and indirectly emerged in the interviewees’ accounts in this study would suggest that the interviewees employed multiple resistance strategies in dealing with the impact of racism. The interviewees in Barnsley were more likely to apply role flexing strategy in which they tried to fit in with the local community by appearing more white than black. The majority of them made reference to the inappropriateness of the dress code of Asian Muslim women as they believed that migrants should not publically display their distinct cultures as it makes them stand out when they should be minimising the impact of negative stereotypes, suggesting the employment of an avoidance strategy. Several of the interviewees referred to adaptation that included mode of dress and speech according to the wishes of society:

*I don’t have to lose any part of my identity, I don’t think so, the only aspect which you probably lose is how you dress and how you talk. Other than that, once I’m inside my house I’m in my own environment, maybe I’ve accepted things which a lot of people don’t accept. There is a void; there is a social gap, for all of us who are immigrants. But you have to accept that and then take it from there and once you accept that you are not thinking about it, worrying*
about it, whatever, but inside my four walls I do what I want to do. When I’m outside I have to do what the society expects you to do (gp2b).

The interviewees in Barnsley also appeared to make reference to navigating fewer city spaces in comparison with the interviewees in Sheffield and Manchester which suggests that their approach employed avoidance strategy. Central coping strategies described were within the domains of ongoing internal strategy, resting on faith, standing on shoulders and valuing oneself. That is, interviewees’ accounts show that they relied on their faith, cultural resources and spiritual beliefs such as destiny and fate. Evidence suggests that specific cultural values were incorporated by individuals who referred to cultural proverbs which emphasised optimism rather than pessimism:

We have a saying in our culture that Jis thali mein khao, us mein ched mat karo (translation, don’t make holes in the plate that you eat out of), it implies that you take care of it because it is providing you with food. There are good and bad aspects of every person and my personal philosophy is... what is he or she to you... there may be 99% bad in you and 1% good in you, if there is even 1% implied by me then you are excellent for me, I should not concentrate on your 99% (gp5s).

Nearly all the interviewees stated how much they appreciated that they had been allowed opportunities for their achievements and that they owe Britain as much as they owe the country of origin:

We only had a few pounds in our pockets, we owe to this soil and people (gp1s).

A few of the interviewees mentioned that they became more engaged with their religious identity than they were prior to migration; however, they believed that this new side of them had been created in the UK. Reference to God was a recurrent theme in several of the interviews:
I was safe not by virtue of British people, God saved me from trouble and I was lucky (gp8b).

A significant number (two thirds) of interviewees talked about their exposure to South Asian poetry and how they utilised its power of communication as it provided psychological resistance and facilitated hope. They combined this strategy with the ongoing external strategy *leaning on shoulders* in the form of social support from their diasporic links, with a significant number talking about regularly attending poetry readings. These collective gatherings were attended by interviewees of both Pakistani and Indian origins, providing only a cushioning effect against adversity, but also promoting cohesion between these groups. This coping strategy may be particular to their relatively elite class and educational background.

There was evidence for the family being the first port of call on which to seek emotional support when the interviewees encountered racial experiences, however, two contrasting accounts came to light which add the dimension of race, gender and class. In one interviewee’s account there was no mention of any experiences of racism until his wife entered the interviewing room to offer some tea and asked if the husband had shared his experience when he had been physically assaulted by a white drug user, and how an Asian taxi driver had saved his life. Though this prompt provided cues to recollect this memory, it also raised questions about the gender difference between the researcher and the interviewee and its implications. In the second interview, the wife (English) also joined the interview and the discussion about racism. Although the interviewee had talked about his experiences of racism at length and how he kept Quranic verses in his pocket and a golf club in the boot of his car as a defensive shield, his wife was adamant that there was no racism in the hospital where they both worked. She accepted that the overseas doctors were kept on a more lowly pedestal; however, her perception was that this related to uncertainties about their overseas qualifications. She talked about class difference and how
she as a nurse observed social distance among consultants, doctors and nurses and that overseas-trained South Asian doctors found solace in making alliances with the nurses (white), in some situations. She added, this relationship often became personal, as their own had done, however, she appeared unable to relate to or validate any experiences of institutional racism. Family may not have been a site of much support in such situations. The least desired personal style strategy *standing up and fighting back*, involving physical confrontation was only mentioned by one interviewee.

All the interviewees in the study appeared to have employed avoidance strategy at some stage. They were uncomfortable in describing people in racial terms and constantly used terminology such as ‘local people’ and ‘Caucasian’ meaning white British or English and ‘our own people’ meaning Asian people. One interviewee explicitly stated how he and other doctors avoided places that were likely to bring them difficulties such as the Working Men’s club where he believed that people, having drunk an excessive amount of alcohol, may be overtly racist. In general, the specific coping strategies that transpired in this study match up fairly well with the framework developed by Shorter-Goeden (2004).

Feagin and Sikes’ (1994) study found that middle class black men and women referred to overachieving as a strategy for proving oneself. In this study, each one of the interviewees talked about innovation, entrepreneurship and the extensive work undertaken to modernise their practices, which could be classed as overachieving.

Although the evidence suggests that the interviewees employed a wide range of strategies to overcome oppression, their tendency to be dismissive about their experiences of racial discrimination on a personal level, is a cause of concern. The interviewees who had retired were more likely to talk about racism than the ones who continued to work, showing perhaps that the former group has had more time to reflect on their lived experiences, whereas the latter group, in addition, may continue to be constrained by an organisational culture where such experiences are not validated. Such a strategy may not only cause harm
to the employee but also cost the employer, and affect the provision of quality healthcare. A small study conducted by Krieger (1990) in California using a random sample of 102 black and white women and a telephone interview, found that the coping strategy used ‘not talking to others about it’ may be ineffective as the results showed that those who were likely to adopt this strategy were 4.4 times more likely to report hypertension than women who acted and talked with others. Many interviewees in their accounts referred to their colleagues’ sudden deaths which is something that needs further investigation.

In this section I examined empirical evidence in relation to the place identity of the interviewees in each of the case study areas. The discussion highlighted that micro-, macro-, and meso-structures contribute towards one’s place attachment and place identity, and while the interviewees had a place attachment to Barnsley, they did not have a strong place identity as did their counterparts in Manchester and Sheffield. The evidence also showed that there was spatial variation in the case study areas and coping mechanisms were adapted accordingly. Now I will turn to how other identities were experienced by the interviewees.

7.4 British Identity

All the interviewees expressed a strong identification with British identity, though the reasons for this identification were complex. As a post-colonial people, already primed, they had a pre-disposition towards a sense of belonging to Britain, a nation they held in high esteem. The interviewees chosen were a select group of individuals who experienced pre-migration exposure to British education from an early age, a medical education model mirroring that of the UK, and positive reception into the UK, that has had a long lasting effect. The interviewees felt a deep affiliation with the UK, despite the fact that they experienced some level of exclusion. They constantly attempted to justify why Britain needed to prioritise their own medical graduates over the needs of overseas-trained
doctors. There was a tendency to look at the larger picture rather than dwell on individual experiences, and there was a sense of gratitude among all the interviewees towards Britain as they could relate to the opportunities that Britain offered. The following interviewee explains how he interprets his sense of belonging to Britain:

> There is a saying in our culture that you should be ‘namak halal’ which means one should be loyal to the benefactors, even if you have only had a pinch of salt from them. When I came, I only had £8 on me and now with God’s grace, I have achieved so much, my children have done well, I have a nice house, status in the community; medicine and Britain have been good for me (gp7s).

Almost all of the interviewees used their own cultural interpretive framework to reflect on their experiences of being in a country that offered opportunities extending to future generation:

> When we came, we bought £3 with us... and there is a man here, his house is here, his whole family is here... he has got house everything... so obviously for our children it is less struggle, so to establish... you built a house from 3 pounds... you achieved something, so you had to establish you can’t get anything without struggling..., one good thing is there was opportunity here to do... if you worked that hard in India or Pakistan it is not necessary that you would achieve, both of my sons are doctors, one is a consultant (gp5s).

With another interviewee stating:

> I have been here so long that the question of belonging does not cross my mind anymore; I belong here and feel part of the society. My children were born and brought up here, they very much feel British. There are better facilities, no corruption, no dishonesty; life is as organised as I had heard about when I was in India (gp6).

For many of the interviewees, their daily encounters with the society at large were different from those of their less privileged counterparts, as the former were perceived as privileged as a result of their particular type of social and cultural capital that held them in good stead.
It would appear from the interviewees’ accounts that Britain has provided them with the distinct social status that they aspired to prior to migration. Several of the interviewees mentioned attending elite social events:

*I love going to going to Chelsea flower show and Royal Ascot every year* (gp1b).

Positive individual experiences in comparison with the country of origin were cited for their attachment to Britain. The following interviewee talked about his deep pride when he received his OBE from the Queen:

*In 2009 I was given OBE, yes this is the picture at Buckingham Palace, you feel very proud, out of the whole country, including Wales and Scotland, I was the only GP in this year given an OBE. I was the community hero for my contribution to public services* (gpm4).

Others talked about their admiration of the ethos of the National Health Service, and also adapting to British values in their lives:

*I think queues are good, whether it’s queuing in the railway station or cinema or wherever, queue is a queue it doesn’t matter. There are a lot of things that are good about Britain and we all need to learn from it, and adopt those values, in particular, the National Health Service, which I think is admirable. Other nice things, punctualities and discipline generally it used to be, it’s all breaking down, err and they used to be very proud about their environment, the streets and so on so forth, now it’s, it’s as bad as any other rotten city anywhere else in the world. I do feel British, I feel happy that I have learnt a lot of good British values, and that doesn’t mean I don’t feel Indian, I know I’m an Indian I feel Indian, because I grew up, my whole formative years were in India, but of course, I do feel British as well* (gp2m).

Fairness and tolerance were referred as British values in many interviewees’ accounts which one can argue is ironic given that they did not always experience them according to their own accounts. However, it suggests that the doctors in the study reflected on their

25 Officer of the Most Excellent Order of the British Empire (OBE).
experiences in comparison with either their countries of origin or other countries, for example, the following interviewee talked about discriminatory practices in other parts of the world, making Britain a better country:

*There’s good and bad things here, good thing is if you came from Pakistan Bangladesh etc, or anywhere else, or from Wales or Scotland, the pay is the same, If you go to Saudi Arabia, there is a hierarchy, if you work in the middle east, Arabic speaking doctors get the highest pay and then other foreign doctors and then the Indian Pakistani doctors, it’s not fair but they can do whatever they like, you see (gp3b).*

The above images of Britain being fairer and more tolerant are partly based on the conditioning that people from ex-colonies have been exposed to, as previously discussed and partly due to personal positive encounters with individuals. The above findings support the assertion of Modood (1992, 273) that though Islam preaches for people to be valued for their virtues rather than their colour and race, and while most Muslims contend that their religion is a genuine multi-ethnic religion, Pakistanis’ experience of Arab racism is such that they would rather work in Britain for less income than in Saudi Arabia for higher income. The author refers to racial humiliations becoming a regular feature perpetrated by shopkeepers, taxi drivers and catering staff, and experienced by diverse Islamic ethnic groups while performing a pilgrimage to Mecca. The interviewees’ accounts showed a great deal of respect to British people for their adherence to the laws and procedures of the country. As one interviewee explains:

*I had more problems with my own people than white people. You meet people who exploit you. When I used to do locum jobs, the practice partners used to make a big fuss when it came to payment, they would say, oh I am not running away somewhere, why are you in a hurry, I am here. They did not appreciate that you have done work and you want to be paid in time. You see the white doctor will never treat you like that, they adhere to the procedures. Many of*
our own doctors didn’t follow the local procedures in employment; he will implement what he knows works back home (gp1m).

For some, Britain also offered sense of security that they did not have in the countries of origin because of cultural, religious and linguistic tensions:

My brother had already been to the UK, he said; go to Britain, the living conditions there are good, there is no discrimination on class basis there, if you are clever, you will make it (gp6s).

The account below shows that integration is a topic that is actively talked about among overseas-trained South Asian doctors:

I think when we sit within our own people, at times, you feel that[integration] missing, and somebody when talked to like this that we got to contribute to British society, then you are considered as ‘oh what is he talking about?’ I think that feeling ought to go away. We are here all my life and I came here when I was 25 years old I’m now 61, so all of the good times of my life they have been spent in this society, good and bad, and who knows in India or Pakistan that 30-40 year time period how these will have been spent but this society has given me so much, I should be grateful to this society, which I think I am, we should as a community also, become a part of it, this is what integration is and these are the kind of values we want to give (gpm4).

The interviewees were often keen to point out that they did not believe they had to give up their Indian or Pakistani identities to become part of the British society:

...that doesn’t mean for even a second that where my warmth to my own country is concerned is lessened, that is even more, I would really want to do something for my society as well, but my duty to this society is perhaps as good as paramount, as... absolutely, I came voluntarily here, nobody forced us to come here, and this society despite what you say has given a lot to us, we just can’t say that ‘oh we’ve been treated as rubbish and slaves and exploited’ and all, yes every society does, Indian and Pakistani are no less. When it comes to exploitation, the amount that happens there, there is no comparison, so we have to accept those things, then become a part of UK society (gpm4).
Another interviewee who previously had said that his reasons for migration were related to political instability in India explained that Britain valued his abilities which may never have happened in India:

Recognition, of my work, recognition of me as an individual is something, and perhaps I would have struggled getting that recognition back home, so in a way you see that, as I keep telling you, cream rises to the top, so when cream rises to the top everybody recognises that, so recognition, identity, whatever it is, they are still a lot better here and I’m proud of my British identity (gpm4).

The interviewee’s reference to *cream rises to the top* suggests that Britain in his view accords opportunities on merit. He explains that exposure to British way of life has made him into a better person and that British society is not as corrupt as his country of origin:

*I like to think, and this is again I’m not a ‘hundred percent judge’ of myself, but I like to think I’m a better person, I have something in me which I want to give, rather than taking anything, so I think in my view, in 30 years it made me a better person, erm now go back to our sub-continent I think the biggest thing which is now hitting both India and Pakistan is the societies’ fabric has corruption in it, you can’t get anywhere without really giving something to somebody, our society is totally, is that a part of this society, answer is yes corruption is everywhere but it’s not to that level.*

He compares the everyday reality in the country of origin and the UK:

*... you can really still get on with what you really want to do in Britain, here you have no problems.. not with milk, sugar, electricity, water or gas. How many times you would have gone to even the income tax office, you wouldn’t have known where your income tax office is, would you ever know who your super-intendant police man was? Would you? In India or Pakistan you will even know who the constables are, leave that, you would even know who the electricity man is... things are very very different and I think those kinds of positivities we should appreciate of this society (gpm4).*
His account below provides evidence of how he very much feels part of British society and is involved in the grassroots politics of the NHS and committed to the enhancement of universal healthcare:

*I’m very much involved in that looking into particularly public health issues, prevention and cure, if we really look into public health issues, even the expenses we were talking about in NHS, we can’t afford it anymore because of so many reasons, obesity related, respiratory related... alcohol related, these are preventable problems, we have to really concentrate our efforts on that if we want universal healthcare to be sustained* (gpm4).

The significance of the role of the media was apparent in several of the interviewees’ accounts regarding a sense of belonging to Britain. It was often mentioned in a negative way, and associated with the negative portrayal of overseas-trained South Asian doctors, however, a couple of doctors mentioned contrasting experiences:

*I got on very well with the local patients; I was often in the newspaper. Once, I was able to diagnose meningitis very quickly with a small baby and sent him straight away to hospital. After a couple of weeks, I was surprised to see the parents; they came with the Star newspaper photographer and wanted my photo with the baby. They said that the consultant had told them that if I had not diagnosed and treated the baby quickly enough, the baby would not have survived and they were so grateful for what I was able to do for them. In another incident, a patient was operated on quickly because I made an immediate referral. The patient came to the surgery with a bottle of wine after he recovered and said he was very grateful, he did not think of me as an Asian* (gp4s).

His comments about bringing a bottle of alcohol as a gesture of gratitude was mentioned by several other doctors, who interpreted this experience as acceptance rather than being offended that their cultural identities had not been acknowledged; this act, for them, confirmed their professional as well as British identity.
Integration into the social fabric of the local community was evidenced in numerous accounts which showed that despite having multiple identities, often human relationships took precedence over any other social hierarchy:

I had a patient [white male] who was always cleaning the outside area of my medical centre. I did not even know this until one day, he came in to see me, his hands had scratches all over and were bleeding. I said to him what have you done to your hands, he said oh nothing much, it was then that I found out that it was him. He said I was just cleaning the bushes; actually I want to keep your place tidy. He died two weeks after, his wife was struggling a little after he died, I employed her as a cleaner, she became very friendly with my wife, it was like a mother-daughter relationship. I had many more positive relationships with local patients. I had 30% our own patients and 70% English patients (gp4s).

Beider (2011, 6) argues that in much of the literature, individuals belonging to white working class communities, are variously portrayed as perpetrators of racial harassment, antagonistic to immigration and with fixed views. However, the account above and others in this thesis show that there can be a bond between individuals that is not always shaped by racialised experiences. The interviewees mentioned such positive encounters with patients with some passion; these were memories which they continued to treasure several years after their retirement:

Ability to understand one another I think. Just by close contact and caring about them you see, interest in their family, their welfare, and that’s how, I mean I’m just not gone there as just their doctor and come out, you go into details about how they’re coping with their lives, their welfare, their next of kin, I mean their children, they get enough support from them or they are getting into any trouble with anyone else like social services... and so and then people, the elderly people living on their own and you feel sorry for them looking out for the ‘meals on wheels’ (gp1b).

The interviewee below talks about how she became ‘bonded’ with the families of patients:
So you go there and see all your patients and then they tell you what goes on in their family, so by going, by talking to them, yes... yes, by talking to them they will tell me everything, what goes on in their family you see, so I would help as much as I could, whatever the system I needed to approach so that’s how I became well bonded to the community. Even now when I go there, the little ones... ‘Doctor, do you remember me?’ (gp1b).

Almost all the interviewees were able to recall occasions where they felt moved by having pleasant encounters with patients, and which strengthened their sense of belonging to Britain:

Yes, one fella [fellow] really caught my... I mean it was so... it... really brought tears in my eyes, he waited for me, you know you see something, in the corner of your eyes, something is not... somebody is watching you.. so this guy was just... I saw him.. he was.. in Meadowhall, I went into the shop, he stood right outside the step, outside the store.. so he stood there... he waited until...I came out, then he... ermm... he said ‘excuse me... Aren’t you doctor...?’ he said.. I said ‘yes’, the minute I saw the face I knew that family, yes because I didn’t see him eye to eye when I went into the shop... although I knew that... then he said ‘Don’t you remember, you... you looked after me ‘all’ my childhood days, now I am working now’, it’s a definite family..[mentions name] you see then you see that face, everything comes back in your head, all that grandparents, mother... mother’s name, father’s name, and this child’s name, everything, so it was a nice gesture that he could remember me, and appreciate the service that was offered to him, as a doctor and as a family doctor, that family doctor was there at that time that bond was there, between the doctor and the family, so he was so grateful and he... family doctor, values were there more than I think nowadays (gp1b).

Notwithstanding the loyalty each individual felt towards Britain, one third of the interviewees also raised their concerns about the sheer inequality that they had personally experienced, mostly by the establishments, rather than the British people:

...45 years I have been living in this country, I have British passport, in general terms, yes, I feel British, in real terms I also say yes because local people also
like us, the majority have worked in India and Pakistan... and Ethiopia. they are used to seeing the world population, and they do like us, the majority of them but when the matter of your other things concern, we feel that there is somewhere some distinction, for example, we get reported too readily, why is it that we have more complaints than the locals (gpm5.)

He adds that that the duty also lies with the responsible bodies if there are competency issues, especially when overseas doctors have stayed in the UK for a considerable length of time:

... we have British [professional] experiences because we have been here for a considerably long time, we have got our postgraduate education in this country, so if we are failing to meet the standards then why are failing. Local doctors have far fewer complaints, it is our view that, I will give one example, only one, there was someone [a white GP] who was alcoholic, living on drink, he would drink a bottle of alcohol and then he would work, if any of us ever did that, we would not have been allowed to get away with that. He was reported, they called him, and said to him, don’t put the alcohol bottle in a visible place, he still continued drinking, he used to be so drunk that he would fall, but nobody held him accountable. Not all of us can do that, if we get reported, it goes right through to the GMC direct, then they investigate, if it’s local doctors, they sort it out between themselves on an informal level. We feel under pressure, and to be honest with you, I have taken retirement for this reason, it’s not my retirement age yet, I could have continued (gpm5).

His account makes reference to ‘we’ which suggests that the above experiences are widespread but individuals may be suppressing them, especially the ones who remain in employment:

I often felt that someone is peeping and seeing over my shoulder, I was extra cautious whenever I was prescribing, I was cautious in Pakistan too but over there I didn’t have this fear that I am being watched all the time, that somebody is watching you, what you are doing. I was investigated once for no valid reason like many of my friends and colleagues but they did not find anything (gpm5).
Migrants navigate or negotiate social pressures in the countries of settlement. They may face different social pressures from within their community either in the country of origin or country of immigration and in a variety of different settings (Bhabha, 1994). The following interviewee’s account would suggest that the interviewees negotiate identity both within the community and across communities:

*I personally think that's the problem lies with us, we Indians and Pakistanis are very very slow, culturally we are so much conscious of the other man or what will the neighbour say, he says what he says and let them say, For example, when we came here to live in this area, my friends, who I regard as very learned men, they were shocked as to where I was going to go to live when I said I am going to live in this area. They said, oh, you are very brave. My friend said that I will be better off in an area where there are apne [own] people, plus you can buy a large house for £40,000 etc. I said it’s a personal choice, if you want to stay in your area, you stay there, I am happy to stay here. I was not happy for my friend to be critical of my choice (gp8s).*

Interviewees’ accounts suggest that some of them were directly caught up in community cohesion issues. For example, one interviewee believed that Asian women must learn English in order to integrate with the wider society, and set up an initiative where his English female patients were linked up with Asian female patients. This was met with some resistance from Asian husbands who objected to the inappropriate code of dress of the English women teachers who came into their homes. The interviewee being from a different religious background did not think there was any merit in those objections. Similarly, an interviewee talked at length about how he also resisted a suggestion made by the PCT for his practice sign to be translated into one of the South Asian languages and erected outside his practice. The gesture made by the PCT seems to suggest that when such a gesture related to an explicit inclusive practice in the area, it was not perceived in the same way by the interviewee and may have related personal prejudices towards a
community who was different from his own in terms of class/culture/religion/linguistic background. The example shows the complexity of the issues involved in such dialogue.

7.5 Diaspora and Transnational Identity

In this section, I will discuss how interviewees constituted diaspora identities in the UK. Diaspora identity, as discussed in Chapter 2, is based on a common ancestral homeland, however, one dispersed with a sense of marginality in the country of residence. The accounts of the majority of interviewees confirm that the bounded solidarity among them developed as a result of surviving in a racist environment. Two thirds of the interviewees, of both Pakistani and Indian origin, stated their interest in poetry and were actively engaged in collective poetry readings. The poetry verses they recited were from the South Asian poets of their era, in particular, Faiz Ahmed Faiz, a well known Pakistani poet who wrote extensively in protest of the post-colonial conditions afflicting South Asia, such as continued poverty, the neglect of the poor, inequalities and injustices, hunger and oppression (Zulfiqar and Husein, 2011). The type of poetry they recited would suggest that they used their love of literature to help overcome racism. One of the volumes of autobiography of African-American writer and poet, Maya Angelou (1997), I Know Why the Caged Bird Sings, in which she metaphorically refers to a bird that is struggling to escape its cage, illustrates how she turned to her literary work and seized upon the power of words to help her cope with racist oppression.

The poetry readings highlight the significance of the role of South Asian languages (Urdu/Hindi) and social spaces in promoting inter-group cohesion which appeared fundamental for individual and group survival. Language appears to have played a significant role as a form of social capital in intergroup cohesion, and in the Urdu/Hindi medium poetry has been used for being revolutionised as well as to revolutionise others.
The view that shared experiences of being an immigrant enables diasporas to develop a sense of belonging to each other that may never have otherwise developed, is also supported by Saxenian’s (2001) study of South Asian engineers in Silicon Valley as discussed in Chapter 2. However, their accounts in relation to how they integrated into the medical world, as well as into British society can also be described using the concept of ‘professional diaspora’ a concept applied by Neiterman and Bourgeault (2012) in their research study with immigrant physicians residing in Canada. The accounts of the interviewees suggest that they formed professional diasporas based on ethnicity as well as professional identity. Almost all the interviewees talked about supporting other colleagues and friends within personal and professional difficulties. The following account shows how the interviewee was able to help another member of the diaspora, despite the fact that he held stereotypical views about Indian origin Hindu doctors:

*I have Hindu friends but I never ask them for help because they never help their own, some of them come to me for help. Dr X, [Hindu] was having problems getting into the local golf club, so he came to me and I introduced him and he managed to get in (gp2s).*

Many of the doctors were affiliated with professional networks and associations, some of the organisations being based on the country of origin such as BAPIO, Pakistan Medical Association (PMA), and some based on overseas professional status such as the Overseas Doctors’ Association (ODA).

Ethnic clustering has been observed to occur among highly-skilled migrants in parallel with low/unskilled migrants. Bornat et al. (2009) draw attention to such clustering in geriatrics which was the result of an intersection of a number of factors such as discrimination, professional hierarchy, geography (the least desired hospitals) and client group (older people). The authors argue for the need to investigate the implications of such ethnic clustering. The process of ethnic clustering in General Practice mirrors that of the
above; however, such diasporas have served to support overseas-trained South Asian doctors in the study, helping them deal with contextual challenges as seen above. The interviewees talked at length with regard to avoiding the formation of tight ethnic networks in their early years in Britain; however, the experience of racism appears to have contributed towards cohesion among them.

Brah (1996, 190) argues that one subtext embodied in the diaspora is that of ‘home’ and while home continues to be a mythical place of desire in the diaspora imagination, it remains a myth and place of no return. On the other hand, ‘home’ is also about the ‘lived experience’ of a place, a locality, and is deeply linked with how the processes of inclusion or exclusion operate and the subjective experiences that occur in particular localities. The findings related to place identity in this study support Brah’s assertion. As the local structures in Barnsley were less inclusive when compared to Manchester and Sheffield, the interviewees from Barnsley articulated a sense of belonging more to Britain than to the place itself. However, the interviewees in Manchester were more likely to experience overt racism, as the changing demography of the patient population did not appear to foster the same close bonds with patients and community that the interviewees from Sheffield and Barnsley talked so passionately about. The fact that they were the only group who mentioned their extensive involvement in transnational social entrepreneurship activities in their country of origin may be related to achieving social recognition elsewhere, as argued by various scholars such as Vertovec (2002), Glick Schiller et al. (1992), and Vertovec and Cohen (1999) who refer to attachments that migrants maintain with persons, customs and interests which do not relate to the interests cultivated in the place of migration. Basch et al. (1994) also add that the racialisation of migrants in the USA that labels and disciplines them as such, leads them to seek alternative identities by means of cultivating transnational ties. Huynh and Yiu (2012) on the other hand, point out that realities at the ground level,
prevent any interest and concern for the home country; such an assertion would certainly hold true for Barnsley.

7.6 Class Identity

Weedon (2004) states that class as a category of identity is significant in social contexts, examples are ways of speaking and dressing, exclusive forms of education, cultural pursuits and membership of particular organisations and clubs. The author argues that class remains a key component of subjectivity and identity, and people certainly know the classes with which they do not identify, even if they do not explicitly acknowledge them according to how they are ascribed by social theorists (Weedon, 2004). Others have argued that what was once an over-riding aspect of identity is now in decline. However, in this study, the evidence suggests that this might not be the case among the South Asian communities as the majority of interviewees appeared to have a strong identity derived mainly from their own occupations. This can be evidenced by the following interviewee’s account which was echoed by many others:

There are very few of our own people here, but there are Asian doctors. You will probably know that doctors usually socialise with other doctors, they don’t socialise with the general public (laughs). So, I never really felt isolated because we had daily interaction with other Asian doctors, either in Barnsley or Sheffield (gp6b).

Class identity was also reflected in their attitudes towards investing in private education for their children as this was considered vital for class mobility. Rex and Tomlinson (1979, 15) argue that the class structure of British society provides opportunities for some sections of the Asian community which are not available to other immigrants, and that Asian professionals have choices open to them to either stay in the state system or send their children to private schools, whereas such choices are not available to working class Asian immigrants (Rex and Tomlinson, 1979, 160). In general, the interviewees were
appreciative of the fact that they had been able to invest in their children's futures and had the resources to pay for higher education, particularly at elite expensive schools. The majority of the interviewees were appreciative of the fact that their children had also made the choice to go into medicine. Such experiences facilitated their sense of belonging to Britain as it offered opportunities not only to them but also to the next generation. The following interviewee talks about the sacrifices he made to achieve his goal of investing in his children’s education:

*My children went to Wakefield School; [Independent] I had to do an 80 mile trip every day for school. We sent them to private school because as you would know we want our children to become professionals and a good education is a vehicle to fulfilling your dreams (gp3b).*

A number of interviewees talked about the negative experiences their children had experienced at school; however, only one identified it as racism, as the child had been called a ‘Paki’, others regarded it as bullying:

*When we came back from Pakistan, we decided we would stay in this country. It was affecting my daughter’s education, she had been to a school already but when she came here she went to a school in Chesterfield, she had some bad experiences, other children used to call her a dupper [stupid], they thought she didn’t know anything (gp3b).*

There was a tendency among many interviewees not to accept racism as a possible explanation in similar situations; this seems to suggest that the external experiences were not validated by the internal beliefs held about a privileged identity. This denial may be related to protecting a system which offered them the class privileges that their unskilled counterparts were denied. Cole and Omari (2003) argue that individuals actively shape class as they engage in different class practices across time and context. The majority of the interviewees were affiliated with organisations that are well known to perpetuate a more segregating than integrating role, for example, service clubs and private schools.
The interviewees may also have sought to shore up a privileged elite identity in order to compensate for an insecure racial identity. Apart from membership of the Lions club, one third of the doctors in this study said they either had been or were continuing to be, Rotarians. One interviewee mentioned being invited to join Rotary Club by a head teacher of a local school in the area where his practice was located. Farmer et al. (2003) point out that in their study, physicians were often associated with social groups that they perceived as being on a par with their professional standing. Very few of the interviewees’ said their children attended state schools. They had the same goals for their children as they had for themselves and viewed education as the primary vehicle for upward mobility. This may suggest the practise of closure and reinforcement of upper-middle class solidarity, however, the following account suggests that this may also be an indication of the doctors navigating safe spaces through membership of BME communities, though this interviewee also highlights cultural difference:

*Lot of my friends were involved in rotary clubs and this club and that club but I was so involved in my practice and family that I didn’t have much time on me. They wanted to integrate themselves and obviously they were not going to go to local working men’s clubs, because they find that the education system was not there, they did not have the same habits, for example,. all Asian don’t drink that much, even if it’s a Hindu doctor, he might only have a little bit but not mad like taking 17 pints every day, you see (gp9s).*

He adds that the working class male may not be as sophisticated or polite. His account shows the fear of being subjected to racial harassment:

*They [Asian doctors] may have wanted to go to working class men clubs but they might have been scared that people in those clubs may not have been so receptive, when people are drunk, they might be babbling and say something of a racist nature. You see, what soberness conceals, drunkenness reveals They may not be so nice, you know, they may be a bit abrupt, they may have not got the educational level, they don’t know, many of them, how to behave sometimes, many of them are perfectly nice gentlemen, I have been to one or*
two working men’s clubs because some patients invited me, one was a wedding party, it was the first time ever I had the experience of going to a working men’s club, they were perfectly alright type of people, you know...(gp9s).

Social identities and differences are also constructed around bodily differences such as race and gender, which can open or close spaces of opportunity (Laws, 1997a). Rich (1986) draws our attention to the fact that our experiences of everyday spaces are based on our material bodies. Although altering the mode of speaking and dressing cropped up in many accounts, and was undertaken to fit in, the above interviewee refers to being conscious of the embodied experiences of himself and the ‘other’, in this case the working class, and their social capital (manners and speaking), which was not appreciated by the middle class interviewee.

Almost all the interviewees talked about meeting the complex healthcare needs of the Asian patients and communities, and while there was evidence to show that many of doctors in the study had tried to address their cultural and linguistic needs, there was also a tendency to describe the BME patients as challenging and more demanding than the white patients, in particular, Asian patients. One third of the interviewees referred to violence and oppression within the Asian community, as though it was epidemic and something the communities brought with them (Keskinen, 2009). The following account shows that the interviewee believes in the existence of homogeneity in the culture of the women that she was dealing with, but that women can change their position by refusal to be coerced:

Asian girls were being forced into arranged marriages and women were not allowed to take contraception by their husbands. There was this girl who came to me one time, her parents wanted to arrange her marriage and force her into it, even though she was born and brought up here [UK] and if she didn’t want to get married there, why should she? I told her if you don’t want it, then no one can force you, you are an adult, it took quite a lot of time, to explain to the victim that the solution was in her hands, the control is within her hands and
she has the power to do what she wants and not be a victim, (laughs), and to stand up for yourself (gpm3).

The interviewee’s assertion that the girl was ‘born and brought up in the UK’ takes no account of the universality of violence against women, and assumes that in the UK is a land that has already achieved gender equality (Keskinen, 2009). The class identities of the interviewees were exposed in their accounts regarding Asian people, in particular Asian women, as evidenced in the following quotes:

‘I’ve seen women from lot of other Muslim countries, they really I think they are much more conservative here or have become over the last 10 years, than people in your Pakistan or in India, even Muslims there in India they don’t dress like this here and that’s why you feel more different, I think you have to, you just can’t have a very rigid appearance or your ideas so you’ll never mix up with anybody. Sometimes I get female patients and it’s really difficult to even examine their ears as they are so fully covered (gp3s).

Ballard (1979) and more recently Ang (2003, 141) contended that a powerful strategy adopted by those who are marginalised or excluded from white structures or western hegemony is that of claiming one’s difference and turning the re-adopted cultural identity into symbolic capital. Cultural resistance has long been an important part of Indian history. For example, the use of cultural symbols was utilised during the independence movement to combat the denigration and devaluation of their cultures experienced by Indian people were perceived as ‘uncivilised and uncouth’ by the coloniser. This included Indian elites such as Gandhi who started wearing the traditional dhoti instead of western attire (Brah, 1985). The above account illustrates that the interviewee had little comprehension that this adaptation of Muslim women may be a coping strategy, and a reaction to the rejection experienced in British society. The evidence suggests that the interviewees’ strategy revolved instead around adopting a symbolic identity of their medical profession rather than their cultural identity. It shows how elites’ strategies differ from non-elites in dealing
with racism. Class identity was also reflected in the interviewees’ reluctance to talk about elite racism, which may have been related to their tendency to stick together with people from an upper-class background to accord each other rank and privilege (Evans, 1988, 65)

In addition to adopting the cultural elite practices of mainstream British, the interviewees demonstrated their elite status within the South Asian group by reciting refined Urdu poetry at our interview. The interviewees’ accounts reveal almost enclave living among the doctors in the study which may have been used as a survival strategy while operating within a racist society. Survival by drawing on cultural capital in the form of class-based power and identities may have consequently contributed to the strengthening of class identity for its maintenance. Although caste did not crop up in any of the interviews, except where one interviewee commented that he believed that Asian educated people living in the UK had grown out of it, further study is required to explore class-based identities and how they intersect with caste-based identities practiced in the countries of origin.

Robinson (1986, 52) argues that differential access to political power and an unequal position in economic production and other markers produce cross-cutting affiliations which consequently lead to stratification in societies. The evidence in this study confirms such an assertion. The author draws attention to the fact that concepts such as ‘assimilation to the host society’ or adoption of its values are problematic when the UK society is an amalgamation of sub-groups with varying attitudes, values, aspirations and political and economic power.

7.7 Hybrid Identity

It is often assumed that the relationship of post-colonial people to Britain commenced only at the point when they or their ancestors embarked on their journey to Britain, failing to take into account their exposure and conditioning under colonial rule (Sayyid, 2004). As
discussed previously, the interviewees talked about being educated at the English medium-stage schools and their medical education being based on the British model. The interviewees’ frequent code-switching between English and their first language is one example of their sociolinguistic hybrid identities (Bhatt, 2013). Almost all the interviewees talked about the ease they felt with their hybrid identities:

\[I \text{ am proud to be Indian of my roots, but I am equally proud to be British and to be in England. I am a Hindu, but not a strict one; I pray at home and celebrate our festivals (gp2b).}\]

The following poetic account shows an awareness of hybrid identity:

\[\text{Hum Log Sunandar Ke Bichrey Huey do Sahil hein}\
\text{Is Paar Bhi Tanhai Us Paar Bhi Tanhai}\]

[Translation: we people are like the two separated seashores that feel apart from each other]

The people from there [India] say you live in England now and become Valaytey [Westernised] and the people from here say we are Hindustani or Pakistani... (laughs ) that feeling is there. Yes that is there, love for home country (gp5s).

Another female interviewee talked about how she chooses what she wants to wear in different contexts. The layout of a consultation room in Britain differs to that of in India and she decides on the appropriate code of dress in the context of her professional conduct in the UK:

\[I \text{ never wore a sari to General Practice because I felt sort of very conscious about it because I think this Indian sari is not right, it’s not practical although you have to, you don’t cover yourself, every part of your body, it is open here and there and particularly when you are dealing person to person in a consulting room that’s not on, so I never wear saris (gp1b).}\]

Similarly, she chose to assert her middle-class identity in a different context:
... but in all the social functions I wear only a sari, even now I am thinking of going to Royal Ascot, I will wear a sari (gp1b).

For some, Britain has provided a sense of security that they did not have in their country of origin, however, they seem able to integrate both aspects of their identity in their daily practices without any conflict. The following interviewee, in his previous account, had acknowledged the negative aspects of being in Britain and talked extensively about his experiences of racism, whilst also formulating a balanced view of Britain:

... this government is good in some respects, there is some good points about this government as well and we must appreciate, you are free to worship, whatever faith you have, it does not matter, your faith is with you, your job is separate, it does not matter, okay, also, I go to bed hoping that, God forbid if I have a heart attack or stroke, I will wake up in the house and not in a prison or somewhere, ok security is there, in India or Pakistan, as you would know, security is not there and most of other countries as well. So, I am thankful to God that we are where security is, so, yes I do belong to England and I have had a British passport and nationality since the 1970s (gp9s).

His account below also shows that the media only portrays a stereotypical image of mosques in the UK:

Well, I belong to England now, I have no qualms about it now, I tell you I celebrated her majesty’s jubilee fantastically, the mosque I went there, we put hundreds of bunting all over there, British flags both sides, union jacks and a big picture of the queen. We had a big dinner there, okay, I belong to a community called the Ahmedia community. You have got to, my own belief is that you believe in Allah, Mohammed, his prophet (peace be upon him) and beside this you follow other duties placed on you, for example, give charity, observe Ramadan and so on, after this, you must also be loyal to the government in which you are living in, this government. (gp9s).
Regarding identification with British identity, the interviewees frequently evaluated new situations through their old frame of reference, which was their own cultural/religious value system and drew meanings from what they already knew:

Adaptation...that question is very debatable, very hot question, if you take the religious point of view, there is a story that Umar Ibn Khattab,[the second Caliph of Islam] was going from one city to another and was wearing silk that day. People objected and said to him, hey, how come you are wearing silk when Islam forbids men to wear silk? He said, the area that I am going to go, they wear silk there. So, my learning from that is that 'jaisa desh waisa bhais' [equivalent to 'if you are in London, do as the Londoners do'].

As discussed in Chapter 5, the motivation to come to the UK was to advance their knowledge of western medicine, however, several interviewees from both Muslim and Hindu faiths talked about how they incorporated their own religious identities into the medical professions and strived to become good doctors.

For example, the following interviewee makes links with the deliberate instructions of Prophet Mohammad:

For me, it's[ being a doctor] a form of worship. It s sunnah\textsuperscript{26} to treat others, our prophet often treated sick people (gp7b).

Another interviewee explained how he integrated his religious teaching into his work:

I also believe in spirituality alongside bio-medicine model of treatment. I would often write a verse from the Quran on prescriptions which was a prayer for healing and was appreciated by white patients too. You see, we all walk separate roads in life but we have a golden bridge called duas [prayers] that link our lives together. Once a white patient came up and asked me what this Arabic verse meant, I explained it was a prayer from me that may he be granted good health. He was very happy to hear that (gp7s).

\textsuperscript{26}The teachings of the Prophet Mohammad (The Fiq of Medicine, 2001)
The above accounts lend support to Parekh’s (2007-133) assertion that religious identities constitute the axis of one’s life and that such identities provide an overarching framework within which individuals define and relate their other identities.

Dadabhoy (2001, 63) a British born South Asian GP, refers to the pressures from both the white and Asian community concerning integration and describes how he experienced a culture of ‘all or nothing’ where his white friends had stereotyped him as an ‘extreme misogynist’ for his wish to adhere to Muslim religious observance, and where he was conscious of being labelled a ‘coconut’ by his Asian friends if he mixed in pre-dominantly white circles.

A few of the interviewees described some aspects of their everyday life that would fit with Mimicry Theory, and could be classed as ‘mimicing’, for example, membership of Rotary and golf clubs. One interviewee proudly stated how they call their daughter by the English name given to her by an English nanny, who could not pronounce her Indian name. This could be interpreted as an integration attempt by some or within the context of mimicry by others.

Many of the interviewees appeared to be conscious of cultural racism, believing that one should not make oneself appear too conspicuous in the UK; this may suggest a coping strategy or a personal choice to integrate into British society:

> In my opinion, Indians and Pakistanis are keeping their culture in this country which I don’t think is proper because the culture is different, the dress is different. You have to adapt to the way of life here (gp8s).

The above views were shared by two thirds of the interviewees who believed that one should adapt to new ways of life and not impose their own way of thinking on others. They believed that adhering to a cultural code of dress can be overbearing for ‘locals’.
The interviewees’ accounts show that they negotiate belonging discursively and by the repositioning of self. Many of the interviewees talked about playing a role concerning the unmet needs of their own communities, but also contributing to the enhancement of community cohesion by connecting individuals with institutions:

*I used to teach Asian children the Quran because there was no proper system for religious teachings; they were children of Indian, Pakistani, Bengali Muslim families. I have been a chaplain for a long time and I visit patients in all of the hospitals in the city, sometimes when someone dies and there is no relative for Muslim families around, I also organise for a Muslim burial (gp7s).*

For many of the interviewees, the construction of social belonging involved the freedom to be able to maintain their multiple identities:

...if you can be Indian you can, you can work in Britain, you know if you are, if you are okay... your language is alright, your language ability... if you are you know good in your job you know if you do it err what is the word, ‘conscientiously’... and you keep a relationship with your colleagues, your friends you know professionally as well as erm I don’t see any problem or any, why should you have to lose any identity or anything you can be an Indian, you can be a doctor, you can be a you know, a student, you can be a psychologist and you can maintain a relationship, you don’t have to lose, you can still you know you can still celebrate your Eid, Diwali whatever, you know in your own time and place and you can still be a very good professional (gp3s).

He places emphasis on ‘work’ which is a medium that enhances his sense of belonging:

*I feel that I provide, I contribute to the community, you know in whatever way little way I do and I feel part of it, yeah,. I think my work is important; I’m working here of course and...the relationship I’ve developed and the knowledge I have gained over the years (gp3s).*
The interviewees’ accounts show how their personal and social identities have been formed in the UK. They talked about how they were able to navigate their multiple identities on a daily basis with relative ease:

*I am Indian and Hindu. I go to Sheffield sometimes because there is a Hindu temple; I also go to Leeds, Bradford. No problem, it does not bring any conflicts to my daily life. I bring my grocery and meat from Asian grocers in Sheffield, even though I don’t have to have halal meat (gp6b).*

Brah (2007), however, argues that there remains a failure to recognise that identity work is never complete, and is always in progress. The following interviewee’s account supports such a view:

*Britishness? That was the question asked by my accountant because I wanted to emigrate altogether to India because of the tax situation, purely that. I raised this question, what are the things I have to do? If I want to emigrate to India... and then she said ‘Oh you should not have any property at all here’, I said when I come here where can I stay, she says ‘You stay with your daughter’, I said ‘That’s not on, I’m not going to lose my independence after all these years, I’ve got to have a property’ then she asked me, ‘Which is your home? Is India your home or is England is your home?’ I told her I have lived in this country longer than I lived in India, England is my home. Then she said ‘You are not going to go to India to settle’, I just left it like that (gp1b).*

Her account below shows that one’s phase of life also has an impact on one’s identity. For example, her retirement and being a widow brought new challenges for her:

*We used to do all our shopping from Asian grocers, I’m not so bothered now because I have to go to Rotherham, so I mean when we were family, my husband used to go to the Indian shop, but now I rarely go... I still have Indian food, yes.... I make my own chappattis, rice, daal, and I go to an Indian shop, but I get a big packet, it will last for one year, so that is there and err vegetables I don’t miss much, maybe when I go I get that Bindis (Indian vegetable), yes, yes, spinach I will get it, coriander and surprisingly that Indian shopkeeper, she was asking me, ‘Why you want to buy coriander, don’t
you grow coriander at home? ’ you see... It put a shame on me (laughs) I could have done so, I’m going to make some effort (gp1b).

Her account shows how she negotiates her cultural identity and the choices she makes in terms of the type of food she can do without. The above account also shows the social aspect of going to an Asian shop where she has a rich cultural encounter with the shop assistant who appears to know her well through these encounters. She talks about experiencing the social isolation that has been created not only by the context (predominantly white), but also its intersectionality with other layers such as gender roles, being a widow, and being single within Indian culture:

*I miss social gatherings, yes, I miss quite a lot. That’s right, it’s not like that, even then, those days we used to invite all the doctors here, we used to have just a great time but now it’s all stopped, I don’t know why, even I haven’t invited all those, I mean when you are in the profession once my husband passed away I didn’t want to do that, that is the main reason for me, because being single, I don’t, but one thing I miss are the social gatherings like so many weddings, so many functions we used to go to, my brothers and sisters [In India] full of praise for all the functions, which I miss it, very much so I really miss that part of... family social gathering. Yes I miss it, we have friends, lot of friends, at the end of the day we are all friends but that family gathering is zero here, no one... which I miss quite a lot (gp1b).*

The empirical evidence shows that the individuals in the study have a strong sense of linguistic, cultural and in many cases, religious identity, however; these identities are not in competition with each other, and in fact, different sources of identity are seen as mutually reinforcing rather than mutually exclusive.

7.8 Summary

This chapter discussed empirical evidence related to socio-cultural integration and explored the post migration experiences of the doctors in the study. The research questions covered were two to four. The first part of the chapter described the specific contextual
characteristics of the case study areas as well as the demographic characteristics of the doctors in the study, looking at how the interviewees came to settle in their respective areas and develop a sense of place. The interviewees’ residential choices showed integration with the local populations including white population with a similar class background; however, in the majority of the cases, this included people of similar ethnic backgrounds and the formation of clusters and networks for mutual support.

The impact of migration on racial, cultural, religious and linguistic aspects of the doctors’ identities was examined and how such identities evolved and were expressed in the context of changing needs and opportunities. The findings highlight how the doctors in the study had adapted to new environments, embedding themselves in local structures, however, the degree of involvement varied according to how inclusive such places were in relation to minority communities. All the interviewees strongly identified with a sense of ‘Britishness’ evaluating their experiences in the context of their own cultural/religious interpretations together with positive experiences in the UK. Where the local structures were less inclusive, transnational identities were more salient than in more inclusive places. The empirical evidences show that while interviewees referred to dealing with pressures from both white and Asian communities concerning the extent of integration, their own cultural, religious and linguistic identities posed no competition with their newly constructed diasporic identities and British identities. The discussion in this section has shown the complexity involved in the formations of identities, and has challenged the notion of one national identity (British). The exercise of separating identities under sub-headings was a challenging task in itself for the fact that they are inter-related and experienced simultaneously. The evidence shows that multiple identities appear to reinforce interviewees’ overall sense of belonging to Britain and being British but with a sustained attachment to their country of origin.
Chapter 8: Discussion and Conclusions

8.1 Introduction

This thesis set out to investigate the structural and socio-cultural integration experiences and perspectives of an elite group of migrants, that is, overseas-trained South Asian doctors in the UK, in order to contribute to contemporary community cohesion debates. Alongside a profile of migrant doctors across England and Wales, case studies were employed across different parts of the UK, in order to gain a greater understanding of how different environmental characteristics impact on the social interactions of migrants and their sense of belonging to Britain. The case study locations were: Barnsley, Sheffield and Greater Manchester. In sum, the empirical evidence includes secondary analysis of the NHS GP workforce database and 27 interviews with overseas-trained South Asian origin doctors in three case study areas in England, comparing areas of relatively high and low ethnic diversity.

The qualitative part of the study explored the motivations and adaptations involved in the migration process of overseas-trained South Asian doctors and how they overcame numerous obstacles in their struggles to establish themselves as UK medical professionals. It examined their career aspirations and realities and how they used entrepreneurial processes to enter into General Practice as a practical solution to the limited opportunities offered in the hospital sector. The findings illustrate how they rebuilt their lives in the UK, setting up GP practices as viable entities. They did so in order to effectively serve the needs of marginalised patient populations, and were simultaneously able to develop close relationships with diverse communities. Several of the interviewees talked about handing their legacy on to their children who had also begun medical careers. The evidence shows that the interviewees had a positive perception of their migration trajectories and a strong sense of belonging to Britain alongside an ability to maintain their cultural identity and
transnational links. The findings discussed in Chapter 7 show how these doctors' own elite positions influenced their social integration experiences positively.

A summary of the most important empirical results is provided in the concluding section of chapters 4-7. This concluding chapter aims to highlight the relation between the theoretical part of this study and the empirical findings. In this chapter I will re-visit each of the four research sub-questions as outlined in the introduction before drawing the findings together. The limitations of this research study will be discussed, as well as the implications for policy making and recommendations for future research will be presented.

8.2 Conclusions on the Research Questions

The main research question that this thesis set out to explore was:

What insights do the ‘lived experiences’ of highly-skilled elite labour migrants such as overseas-trained South Asian doctors add to our understanding of community cohesion?

8.2.1 Research Questions 1a and 1b

1a) What were the proportions of overseas-trained South Asian doctors in the total UK GP workforce over the period 1992-2009?
1b) What were their demographics, key locations of employment and how did this pattern change?

Research questions 1a) and 1b) were This question was designed to explore how overseas-trained South Asian doctors had been incorporated into the medical labour market structure and concerned structural integration. Chapter 4 discussed the empirical results, with the key aspects that emerging from the descriptive analysis being that overseas-trained South Asian doctors constituted a significant proportion of the GP workforce between 1992-2009. This pattern has remained steady over the years with few fluctuations. The evidence of a significant numerical presence supports claims that in earlier decades, before 1992, the
NHS was heavily reliant on migrant doctors, and in particular, overseas-trained South Asian doctors, and still is today. The other most basic difference between the overseas-trained South Asian doctors and the remaining groups lies in their distribution by age, sex and the geographical locations in which they tended to settle. This regional variation and their disproportionate geographical clustering in what can be considered as the least desirable practice areas suggests such patterns could be a product of a number of factors including discrimination. The qualitative research aimed to explore the doctors’ own perceptions regarding their social mobility, structural constraints and the discrimination that they experienced. These findings are discussed in research questions 2-4.

### 8.2.2 Research question 2

2) What perceptions do overseas-trained South Asian doctors have of their mobility in the NHS in terms of working conditions and career development and of their contributions?

The qualitative evidence relating to this question was discussed in Chapters 5 and 6. These chapters examined how poor working conditions in the NHS, inaccessibility of training posts, and the perception of a glass ceiling had led to the doctors’ departure from hospital jobs and subsequent entry into General Practice. Though the term ‘institutional racism’ was only used by a few of the interviewees, their accounts identified several ways in which structural factors served to disadvantage them and confirmed that the phenomenon of geographical concentration in deprived and remote areas (as identified in Table 4.8) was not accidental; instead it was a result of what the interviewees perceived as systematic structural inequalities embedded in the NHS.

These findings raise questions concerning the functional aspect of the integration of overseas-trained South Asian doctors. The interviewees’ accounts related to entry into General Practice and unequal geographical clustering, clearly demonstrate that they were
denied equality of opportunity. The unequal spatial distribution pattern of overseas-trained South Asian doctors shows that despite being an elite group of migrants, there are parallels to be drawn with the experiences of low/unskilled South Asians. Nearly all the interviewees referred to what Samers (2010) describes as ‘socio-professional downgrading’ which stimulated a desire for independence, and to be protected from discrimination, despite the fact they were often ambivalent about describing any actual experiences of being discriminated against. Section 8.3.2 Entrepreneurship and General Practice summarises how the doctors engaged in entrepreneurial processes and how their experiences bore a resemblance with minority ethnic entrepreneurs in general.

This finding lends support to Robinson’s assertion (1988, 467) that the concentration of Indian GPs in deprived practice areas following the departure of UK qualified GPs migrating overseas in search of more conducive environments, can be considered a replacement labour force, although in ‘different economic sectors and at different levels in the occupational hierarchy’.

As discussed in Chapter 2, Navarro (1978) has illustrated how deep seated class inequalities in UK medicine have persisted, leading to a division between hospital medicine and General Practice, the latter being perceived as an inferior specialty. Navarro’s analysis does refer to race inequality; however, it does not accord equal attention to race inequality issues as it does to class inequality. The overwhelming evidence from the interviewees in this study suggests that the career advice given by the consultants to the doctors may have been biased with a view to maintain the class and race hierarchy within the structure of hospital services, also that racism within the NHS is merely a reflection of racism prevalent within UK society more broadly. Based on the empirical evidence, the overall finding concerning structural integration is that the experiences of the elite migrants in this study are not dissimilar to that of their low/unskilled counterparts because of also being constrained by their race. There was, however, an ambivalence among these elites to
name racism, in particular, elite racism, (for instance, to describe their experiences with individual consultants as racially oppressive), which may be linked to their race and class affiliation and professional allegiance. I argue that these superiors acted as mechanisms of institutional racism and became what Massey et al., (1975, 10) describe as ‘the reluctant instrument of the establishment’ for not challenging inequalities in the system. The authors point out that institutional racism can persist without ‘racist villains’ (Massey et al., 1975, 10). The interviewees’ individual stories as to how they secured work in their early years expose the informality of the system and the power that the consultants wielded when they would travel all the way to India to ‘cherry-pick’ overseas-trained South Asian doctors, as described by one interviewee. While these consultants appeared to appreciate individual doctors’ skills and experiences, the available evidence suggests that they colluded with the system rather than challenged the oppressive practices that operating to pigeonhole overseas-trained South Asian doctors at the time in certain specialties and at lower ranks. According to The Macpherson Report (1999) this collusion and inaction amounts to the collective failure of an organisation embedded in processes, attitudes and behaviour amounting to institutional racism.

The findings in this study confirm what Oikelome and Healy, (2013, 557) argue, that the human-capital protection of qualifications, profession and status is not sufficient to equate the experiences of overseas doctors with those of UK-trained doctors, resulting from an intersection between race and place of qualification. This study supports the view that the ethnic penalties that often remain for migrants in general also affect elite migrants. The interviewees’ accounts provide compelling evidence that they were channelled into General Practice intentionally despite the fact they aspired to become specialists. In addition, the doctors experienced further structural constraints in the form of spatial accessibility that resulted in their geographical clustering, which Ellis et al. (2007) argue is just as significant as social access to jobs. This finding strengthens arguments presented
by Raghuram et al. (2010) that it is crucial to explore how non-migrant networks may reproduce privilege and shape labour market opportunities for migrants. This was exemplified in the ways in which interviewees described their access to elite networks such as Rotary and golf clubs in order to gain elite membership.

8.2.3 Research questions 3-4

3) How have different contextual factors impacted on the overseas-trained South Asian doctors’ identities and their perception of the communities around them?
4) What insights do the ‘lived experiences’ of these highly-skilled elite labour migrants give to our understanding of community cohesion, and how do their experiences relate to existing theories of migration, social capital, entrepreneurship and transnationalism?

Research questions 3-4 are grouped together as they link with the topic of socio-cultural integration and will be explored together. Chapters 5, 6 and 7 covered the empirical findings in this area.

Firstly, I will discuss the findings related to the impact of contextual factors on the identities of these elite migrants. There was variation in the characteristics of the case study areas as discussed previously. However, the interviewees in all three areas described being accepted by their neighbourhoods and were aware that their elite status had afforded them symbolic capital that had facilitated integration. The interviewees’ accounts showed that personal experiences such as exposure to western education in their country of origin had also contributed towards their integration in British society, and they were more likely to be accepted by the wider society than their low/unskilled counterparts. Being a member of an elite club membership of elite clubs is one such example. The specific characteristics of the place such as rural context and its need to sustain healthcare provision may have also facilitated the integration process. On the other hand, doctors in urban areas were more likely to report an experience of racism.

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Social contexts influence how immigrants’ identities are expressed in settlement countries (Mandel, 1989). Experience of marginalisation and exclusion within the structures of white or Western hegemony leads minority ethnic groups to form diasporic trans-national links.

Determining factors for social integration for the doctors in this study were their own elite position in the form of a professional identity which served as their social capital, the receptive nature of local contexts, support from professional diasporas and length of service. Their ability to adapt to new situations proved effective whether that involved applying the theory of mimicry (acquiring membership of elite organisations such as Rotary and golf clubs) as well as reworking this theory, including being at the level of patients from lower socio-economic backgrounds in their interactions (such as attending private functions held at Working Men’s Clubs). These elites also integrated their own cultural and religious values which they frequently evaluated in new situations, drawing meaning from what they already knew.

Chapter 7 provided empirical evidence concerning how the doctors in the study came to inhabit places, and how place impacted on their sense of belonging. It also showed the cross-cutting affiliations of individuals for social and historical reasons, and how the doctors simultaneously experienced several identities. The assertion made by several scholars such as Tyler (2012), Brah (1985), and Cox (1948), that there is an entwining of the discourses of race, class and coloniality is confirmed by the empirical results of this study. The doctors here are a self-selected elite group of individuals who have been predisposed to a British education and formed hybrid identities as post-colonial people prior to migration. Their accounts showed that they had multiple identities in process, and the findings support Brah’s (2007) assertion that individuals are situated across various processes of identification, which change and lead to configuration into a specific pattern
in a particular set of both social and psychological circumstances, making a particular identity prominent at a given time. Examples of evidence include the practising of various identities such as religious, cultural, linguistic and professional identities, as well as how one’s phase of life impacts on identity.

As previously stated, the specific UK contexts served as spaces where the identities of doctors and patients were simultaneously negotiated against a backdrop of the legacy of Empire. For example, the interviewees described how some patients in urban areas showed their arrogance through their body language, which the doctors perceived as not wanting to see an Asian doctor. The doctors did not perceive white working class patients as coming from lower strata, but rather saw them as English first. Numerous examples were provided in which brief encounters with such patients left long lasting and positive emotional impacts on the interviewees, even several years after their retirement. One doctor described his patients as ‘extended family’ and another stated with pride how they called their daughter by an English nickname given to her by an English nanny because she could not pronounce the Indian name. In all three areas, where social interaction was described with white members of the community, it was, interestingly, mostly with individuals from a lower middle class/working class background. Interactions with upper middle class white professionals were rarely mentioned, apart from through membership of elite clubs, which may be an example of the interviewees’ class affiliation. The evidence shows that the doctors in the study were able to reach out to certain social groups that are generally inaccessible to low skilled migrants, for example, Rotary Clubs and prestigious sports clubs because of their elite positions based on their professional identities. It can be argued that their class position helped mediate their ethnic identity, implying that racism operates in a particular way, and that there are factors that act as mediators. The evidence in the study shows that the doctors’ professional identities were more salient where local structures were described as less receptive and reflective of diversity, for example, as in the
case of Barnsley. In Manchester, although the city is diverse, the evidence from the interviewees suggests that they were more likely to experience overt racism here than in other case study areas because of the city’s unique urban characteristics, including a relatively high ethnic density (associated with low levels of trust) and a higher level of poverty, possibly leading to competition over scarce resources (Bonnett, 2000, 132). Working conditions here were described as less rewarding than in other areas, and this may have contributed to doctors adapting transnational identities which offered the opportunity of being valued elsewhere. In Sheffield, the interviewees appeared to have strong local and national attachments; may be due to the local structures being more reflective of, and valuing of, diversity than other areas, as well as the city’s environmental ability to offer safety, peace and a more middle class lifestyle.

In relation to British identity, a strong identification was evidenced by all the interviewees, though they combined it in different ways. For many, this identification did not simply start on their arrival in the UK; it was something they had been exposed long before. Many had retained the belief that Britain was a fair country, and a place where they had been able to achieve better futures for themselves and their children without being exposed to the specific forms of oppression experienced in the countries of origin such as those related to caste and the social standing of their family in the community.

In relation to integration into British society, the responses of this elite group of migrants were distinctive in that the majority of the interviewees believed in having a ‘public conforming identity’ with few distinguishing aspects, and did not approve of some of the visible performative acts exhibited in the behaviour of other Asians, in particular Muslims dressing in so-called ethnic clothes. A general consensus was that some aspects of ethnic identities should not be shown in public and instead confined to the private sphere. This was rationalised because visibility brings out an implicit claim of identification, which
suggests that the doctors were aware that maintaining an ethnic identity in public negates the socio-cultural conformity expected by UK society (Antonsich, 2012).

The phrase ‘When in Rome, do as the Romans do’, was only mentioned by a couple of interviewees, nonetheless, it captures the general attitude of many doctors in the study, across the three case-study areas. While many Asians in the UK may affirm their ethnic identities symbolically by way of dress, the elites in this study achieved this by means of belonging to diasporas which positively affirmed their ethnic identity. They also frequently used their professional identity to shield them from any potential hostility, which in my view, relates to the coping mechanisms of elites, and possibly by their professional socialisation that emphasises the neutrality of doctor-patient interaction as referred to by Beagan (2003).

There was some evidence of challenges arising out of such expectations, for example, one doctor described how his residential choice to live in a predominantly white area was frowned upon by a fellow South Asian doctor. This example shows that, although the class position of the doctors afforded them the privilege of making residential choices, this was perceived as lack of conformity to own community by a fellow doctor. This strongly indicates the shortcomings of the existing community cohesion theories which need to consider other processes of integration because they often approach the process of cohesion as simply two-directional.

The qualitative evidence exposes the heterogeneity that exists within British society due to individuals’ differential access to political power, and their differential location in relation to the economic production that generates stratification in any society (Robinson, 1988). For example, the doctors in the study had a perception that their doctor-patient relationships were of a reciprocal nature rather than asymmetrical, as such interactions involved marginalised patients and marginalised doctors, thus exposing the complexity of
whiteness, class and cohesion, and the fact that not all white identities are privileged (Beider, 2011).

The findings also show that the majority of white working class people were perceived very positively by the doctors in the study, rather than being pathologised. These findings also challenge the conventional theories on the doctor-patient relationships in which those with the possession of medical and scientific knowledge have been described as powerful groups that are privileged over others (Lupton, 2012).

Cultural difference is perceived as a threat to national identity as it is assumed that there is cultural homogeneity within the UK society (Castles and Miller, 2003, 248). The language and culture of the migrant has become symbolic for ‘otherness’ and are ‘markers’ for discrimination. The interviewees’ accounts do not indicate that retaining one’s own cultural/religious/linguistic aspects is an aspiration towards separatism. Rather, they show that such attributes were, as argued by Bhatt (2013) as a mode of resistance and an act of decolonisation rather than an aspiration of separatism. The type of poetry (revolutionary, and written by poets who took on a literary campaign against colonialism) recited collectively by the interviewees can be seen to strongly relate to the mode of resistance adapted in the post-colonial context.

Opposition to different languages and cultures is justified on the basis that as the official language, English is crucial for economic accomplishment, with the migrants’ own cultural and linguistic attributes proving insufficient for success in a modern secular society (Castles and Miller, 2003, 248). In contrast, there is qualitative evidence clearly demonstrating that the main Asian languages of Urdu/Hindi played an important role in the strengthening of bonding social capital and offered culturally sensitive coping mechanisms. The findings in this study show that all the interviewees expressed pride in their ethnic/religious and linguistic identities, alongside their British identity. Their
accounts showed how they integrated their own cultural values positively in their work ethos and adaptation to Britain, and drawing strength from the revolutionary writings of poets from their era. The empirical evidence shows that their own cultural/religious/linguistic identities posed no competition to their newly constructed diasporic identities and British identity. However, being British was only one of a range of identities experienced by the doctors in the study and supports Parekh’s (2007) assertion. The interviewees’ sense of belonging to Britain was described in relational terms. In other words, it was based on Britain’s ability to offer better opportunities than the interviewees’ countries of origin and the freedom to practice cultural identities. This shows that the concept of Britishness needs to be re-defined and broadened to encompass the views and experiences of its minority communities.

I will now turn to the remaining part of question 4 which asked how the experiences of elite migrants overseas-trained South Asian doctors relate to the existing theories of migration, social capital, entrepreneurship and transnationalism. The discussion in this chapter has already covered the empirical results regarding transnationalism, therefore, in the following sub-sections I will discuss what the empirical results of this study add to the existing theoretical concepts of migration, entrepreneurship and social capital.

8.2.3.1 Migration and the Elites

Empirical evidence relating to the migration process and the role of broader social structures in shaping migration patterns alongside individual agency was discussed in Chapter 5. The findings showed an intertwining of macro- micro- and meso-level structures involving a complex set of social, cultural, political, historical and religious factors shaping the migration pattern of large numbers of overseas-trained South Asian doctors into the UK. It confirmed that people display different migration patterns according to their occupational class and context (Andall, 2000).
The role of the family has been stated as central in migratory movement from the Indian sub-continent countries (Castles and Miller, 2003). However, this was not always the case for elite migrants in this study. Similarly, the driving force for migration was described as the obtaining of post graduate qualifications, acquiring a fellowship and gaining professional experience in UK hospitals, with a view to enhancing career development, rather than for economic reasons. The doctors mostly utilised institutional networks that they had relatively easy access to such as the GMC, rather than relying on traditional kinship networks as did their unskilled counterparts. Several of the interviewees came to the UK as part of a couple which shows that temporary highly-skilled permit holders were once allowed family migration, contrary to the mass migration of low/unskilled people from South Asian countries where men arrived first. The creative use of religion was clearly evident in the doctors’ accounts, not only in their decision-making processes, but also with regard to its provision as a spiritual resource. Their accounts show that the psychological effects of religious values resulted in their commitment towards enduring the hardship of their migration (Hagan and Ebaugh, 2003). The evidence shows that aspects of their culture, language, religion and values, became integrated in the organisation of the migratory process.

The findings show that the kind of reception they encountered differed from that experienced by low/unskilled migrants and in comparison, the doctors had more positive experiences. The exemption from strict immigration control, and the availability of clinical attachments with relative ease, job opportunities in Britain including vouchers and work permits, all facilitated migratory movement and was intentionally designed to overcome the shortage of medical labour in the UK, factors from which the majority of other non-professional potential migrants from these countries were excluded.
8.2.3.2 Entrepreneurship, Social Capital and the Elites

The empirical evidence relating to the entrepreneurial behaviour of the doctors in the study was discussed in depth in Chapter 6. Nearly all the interviewees described experiencing ‘socio-professional downgrading’ as paraphrased by Samers (2010) which stimulated a desire to be independent and protected from discrimination. The empirical evidence shows that apart from blocked social mobility in terms of hospital medicine, spatial accessibility to jobs to General Practice was a further structural barrier as they were not able to access jobs in well sought-out practices.

The evidence showed that the entrepreneurial process was greatly facilitated by collective interests, strong personal ties that led to the pooling of labour, and financial resources showing similarity with the processes experienced by other ethnic entrepreneurs. Ethnic entrepreneurs use family as social capital, whereas for the interviewees, it was other overseas-trained South Asian doctors who provided their social capital.

The detailed accounts of the interviewees show how both the values and norms on which social capital was based and social capital itself, were socially remitted by them in the new settings (Levitt, 1998). For example, specific individual-level and group-level characteristics such as ‘bounded solidarity’ and ‘enforceable trust’ were sources of social capital that the interviewees utilised as a resource. Another distinguishing aspect of their contribution was that their collectivist perspectives were embedded in bonding social capital that produced positive outcomes for them in a society which is highly individualised and less likely to reproduce a similar form of social capital. Such approaches also facilitated resource mobilisation in the geographical locales that had struggled to recruit GPs in the past as the interviewees were able to instantly draw on their connections with doctors form similar backgrounds. The evidence in the study shows that the interviewees were able to combine resources in novel ways so as to create something of
value and were able to build special relationships with a wide range of people and communities to whom they provided enhanced primary care services. The interviewees’ accounts show how they employed strategies to meet the needs of a diverse population which varied according to social context, for example, the application of the theory of mimicry, acquiring membership of elite organisations such as Rotary and golf clubs, imitating the cultural attitude of the upper middle class British, as well as reworking this theory, including being at the level of patients from lower socio-economic backgrounds in their interactions such as attending functions held at Working Men’s Clubs.

Evidence in the study also suggested that the roles played by these elites merit the role of a social entrepreneur. The interviewees were able to leverage the prestige and professional status they had acquired in the UK to their advantage in their countries of origin and had set up various initiatives within state run hospitals.

A key component of the community cohesion framework, as discussed in Chapter 2, has been the application of the social capital framework in its ethos, where bonding social capital refers to social ties within various community groups, and bridging refers to social ties across social groups. Emphasis is placed on ‘bridging’ social capital to achieve cohesion among communities. Research question 4 asked how the experiences of overseas-trained South Asian doctors relate to the social capital theory. Chapter 6 discussed in depth the experiences of doctors from migration to negotiating entry into General Practice and explored how bonding and bridging social capital came to bear on their experiences. The findings show that the doctors in the study came from different cultural and religious backgrounds and were not a homogenous group of people. They had to deal with internal conflicts as discussed in section 6.6 The Downside of Ethnic Entrepreneurship. In other words, what may be perceived as bonding social capital can also be simultaneously interpreted as bridging social capital as the doctors were bridging social ties across social groups within South Asian communities.
The findings showed that the doctors in the study came to the UK to invest in their human capital by acquiring a western education which would promise them social status in the prestigious profession of medicine (Husband, 1982). While the interviewees appreciated the opportunities the UK offered, in reality they also they found isolation and ghettoisation in the NHS; also the experience of like many other migrants in new settings (Laws, 1997). The process of migration and the negotiation of entry into General Practice in this study shows that ethnic social networks previously considered insignificant by the doctors in the study became significant in combating exclusionary/marginalising practices by the UK-trained GPs, and led to the strengthening of ethnic identity. For example, they later developed exclusionary practices in their own recruitment procedures and mostly appointed other doctors of a similar background, which shows the negative side of bonding social capital as stated by Khan (2007). The evidence in this study shows that the majority of the interviewees had initially wanted to make a bridge with individuals and institutions rather than rely solely on friends’ networks that constituted bonding social capital. However, the entrepreneurial process described above shows the contrary and the findings lend support to Khan’s (2007, 46) assertion that individuals are more likely to seek social ties among fellow members who are unable to participate in institutions of power and are discriminated against by those who profess to include them.

The findings of this study lend support to Khan’s (2007) assertion that bonding social capital eventually allows individuals to participate with increased confidence and engage with institutions of power. This was true for several of the doctors in the study, who were only able to penetrate the system by means of networking with other overseas-trained South Asian doctors. The interviewees acknowledged that they drew strength and support from the existence of such social networks. However, they also recognised that such links reproduced oppressive practices and that this form of social capital also contributed to exploitation. The finding that can be derived from this empirical study is that community
cohesion should not be seen as an issue that is purely white versus BME communities, while Britain’s BME communities also need to strengthen their social ties within before they can create bridging ties across wider social groups. There is some merit in Khan’s recommendation that bonding social capital is a positive resource for migrants, which this study has also established and given the government’s own interest in equal participation for all, it should invest in supporting bonding social capital. The oppressive practices, I believe stem from the outcomes of lack of responsibility on the NHS’s part as articulated by the interviewees (being informed that PCTs could not intervene in the GP practices’ affairs for their self-employment status), possibly the cultural aspects such as religion, the region one comes from, and status in the country of origin. Further research needs to be undertaken to establish the causes of intra-group exclusionary practices.

The empirical evidence highlights that the doctors in the study were excluded from mainstream networks, which pushed them into utilising networks with other overseas-trained South Asian doctors. The findings strengthen the assertion of Raghuram et al. (2010) that further empirical research needs to be done to explore the process of how these networks operate relationally between migrants and non-migrants, rather than focusing entirely on migrants’ networks.

8.3 Limitations of the Study

Like any research this study has limitations which should be taken into account when considering the conclusions of this study. The initial research aimed at exploring the scale of migration and the characteristics of a locality over a longer time period in order to obtain a more comprehensive understanding of whether the observed pattern remained stable. However, the availability of the dataset over the period 1992-2009 restricted analysis before this time. The qualitative sample in this study consisted of overseas-trained doctors of Pakistani and Indian origin only, therefore, the term ‘overseas-trained South
Asian doctors’ was restricted to these two groups. Chapter 3 described the methodological considerations in depth which guided this study.

A large part of this study is of a qualitative, case study nature and so there are limits as to what can be generalised. Moreover, the researcher’s own identity plays an important role in the research process, for example, Chew-Graham et al. (2002) refer to own research which involved peer-interviewing (a GP researcher interviewing GPs) and illustrate the advantages and disadvantages of the duality of their roles. The authors emphasise the significance of transparency in reporting and discussing results. I have described in detail how I minimised such limitations in sections: 3.4 Reflexivity in the Research Process and 3.12 Personal Reflexivity. Though a researcher is always implicated in the research process of all qualitative methodologies in one way or another, however, this does not mean that valuable insights cannot be gained.

Its limited sample size also means that the data analysis is not large enough to make conclusions representative of all overseas-trained South Asian doctors in the research case study areas and in other cities and countries. In addition, the responses of the doctors in the study are based on their own recall, while patients’ perspectives are not incorporated in the analysis.

8.4 Policy Implications and Ways Forward

This thesis has consistently shown that though the elite positions of the doctors in the study as healthcare professionals placed them in a privileged position, they often simultaneously had similar experiences to their unskilled counterparts. In this section, I will draw the findings together and discuss a number of key policy implications stemming from this research.
8.4.1 Implications Related to a Community Cohesion Framework

The empirical evidence relating to social capital showed that the creation of bonding social capital was an important approach for the doctors in the study as it provided them with the necessary resources to overcome blocked social mobility. This finding lends support to Khan’s (2007) assertion that the fostering of social ties within homogenous groups is linked to the failure of institutional support and that such ties allow them to participate as equals and with more confidence in UK institutions. The findings support the view that the ‘social capital cure’ underpinning the community cohesion policy detracts attention from the implications of the politics and practices of racism and discrimination, which are often underplayed in initiatives that promote social capital (Cheong et al., 2007). I strongly agree with the author that it is important to have an alternative conception that takes account of understanding the immigration process and the contexts of migration; this is because it is these contexts that equate the experiences of overseas-trained south Asian doctors in this study, who are elite migrants, to the experiences of unskilled migrants with South Asian origins, rather than their human and social capital. What that means is that overseas-trained South Asian doctors experience structural inequalities and this relates to the context of their migration, rightly described as ‘indentured labour’ by Esmail (2007). For example, the doctors in the study talked extensively about their poor working conditions that involved employment in temporary positions and being kept on the lower rungs of hospital posts.

Bridging social capital is championed in place of multiculturalist policies where the latter is said to have caused residential segregation, and the former is anticipated with cohesive communities (Khan, 2007). The evidence in this study suggests that although the doctors did not live in ethnic ‘enclaves’, they did mention living close to other South Asian doctors for the purpose of mutual support, rather than in order to self-segregate. The interviewees also described privileged white people who also tended to live in a secluded way. They
described how their negative bonding social capital is rarely seen as problematic in comparison to disadvantaged ethnic minorities who tend to be pathologised (Wetherell, 2007).

Linked with bridging social capital is the promotion of ‘contact theory’, which as discussed in the literature review, proposes that bringing people from different groups together for purposes of collaboration can reduce prejudice. The findings from this study suggest that such a view is over-simplified, as what appears to matter most is not the quantity of interactions, but rather the quality of such interactions between people of different backgrounds (Allport, 1954). The evidence in the case study areas illustrates the above point, in particular, in Barnsley. As Barnsley’s social structure lacked culturally appropriate opportunities for social interaction for the interviewees, they expanded their spatial radius to neighbouring cities/towns by going on regular trips to mingle with friends there tended to be from similar cultural and social status backgrounds. Zones of contact with local people tended to be supermarkets, and encounters were brief; however the evidence in the study highlights that what was important in these encounters was the type of pre-existing relationships they had and which made the contact meaningful leaving such lasting effects that the doctors remembered the incidents despite having retired several years previously.

According to Hewstone et al. (2007) contact between groups with strong identities can produce two types of outcome, one where the outcome is an increase in prejudice and competition, and secondly an outcome where the diametric opposite occurs, leading to increased positive attitudes and lessening of conflict. The authors drew attention to the significance of a power relationship for achieving positive outcomes between groups. This study has shown that the doctors in remote areas and inner city deprived areas were able to do their jobs as professionals and win over the trust of individuals and communities because their professional background mitigated other aspects of their identities. They
reported how local PCT structures enabled their entrepreneurial processes and allowed them to set up practices. This, I believe happened because there were shared goals, the PCT had an obligation to provide a service in areas that had been abandoned by UK doctors in pursuit of better opportunities elsewhere. The findings of this thesis lend support to the views of Hewstone et al. (2007) who contend that having a co-operative task and shared common goals in environments where cooperation, rather than competition is encouraged for scarce resources, is crucial. The authors add that this contact between groups needs to be legitimated by means of institutional support. The empirical evidence showed that the fact that the GP practices were being managed by these doctors implied that the doctors did have institutional support, which contributed towards positive outcomes in terms of social interactions. This may not be achievable by a migrant who is economically disadvantaged. Conditions under which group encounters occur are also stated as crucial, and different kinds of contacts are likely to bring different kinds of solidarity (Phillips, 2007). The evidence in this study showed that the doctors had a perception of a close bond with their white working class patients. Apart from the imperial element that both the patients and the overseas-trained South Asian doctors brought to their encounter, the asymmetry in the power relationships, in my view, was partly owing to the overlapping experiences of marginalisation and was the result of increased contact under difficult but shared circumstances, as stated previously. In his study of ethnic relations in prisons, Phillips (2007) observed that 87% of prisoners held a positive view of relations between ethnic groups, while interestingly, only 59% the British population shared that view. Phillips concludes that this may be related to the fact that prisons offer much more intensive contact with members of other ethnic groups than is possible outside that environment. The findings in this study highlight that what was significant for the interviewees was the creation of the conditions for a cohesive and fair society (which led to an interviewee referring to his patients as extended family). This was advocated in a
foreword by Bhikhu Parekh in Modood et al. (1997), although in this case, it was the institutional support and co-operative tasks at hand that were highlighted. However, there is no reason why such intimate relationships of trust evidenced in doctor-patient relationships cannot extend to other situations provided supportive conditions are created.

This study has also highlighted that community cohesion is a phenomenon that cannot always be measured by indicators prescribed by the government; Parekh (2002) advocates for contact and meaningful dialogue whereby people can communicate with each other and in places where this kind of dialogue can happen such as across cultural playing fields. There were numerous examples that the interviewees were able to recall where there was an element of experienced cohesiveness despite race and class differences. For example, a doctor describing how a white patient undertook gardening work at the back of his GP practice building without the interviewee’s knowledge, another doctor saying how an encounter with a patient brought tears to her eyes because he waited for a considerable length of time outside a shop to be able to talk to her, although she had been retired for several years, while another doctor repeatedly referred to his white patients as his ‘extended family’, these are only a few of the examples described by the doctors in the study. Community cohesion, in my view should be, as Wetherell (2007, 4) argues, about fostering such casual exchanges as pleasantries in shops and pubs with regular contact that strengthens what remain weak ties for many people.

8.4.2 Policies Need to Reflect That Identities Are Plural

Discussions around identities revealed that while the interviewees showed strong identification with the British way of life and values, they also positively incorporated their own cultural values into the mix, and drew new meanings from them. The evidence in this study strongly points out that the meanings of the term ‘British’ will need to become more inclusive of the experiences, values and aspirations of ethnic minorities so that migrants
can become citizens with equal rights and an integral part of the national culture, in the implementation of the community cohesion framework. While there is some mileage in Putnam’s assertion that bridging social capital requires that we ‘transcend our social and political identities to connect with people unlike ourselves’ (Putnam, 2000), policy frameworks need also to consider the psychological aspects of one’s identity. In addition, policy makers need to bear in mind that ethnic identities are far from being ‘pure’ or ‘static’, indeed the interviewees in this study referred to spaces of negotiation both within and across groups, supporting the point that Hall (1992, 252) makes whereby sharing social spaces with others from different cultural backgrounds inevitably leads to transformations of identity. For example, many Indian origin interviewees of Hindu background talked about dietary changes, for example, moving from being strict vegetarians to purchasing halal meat. The dress code of a female interviewee was also adapted to what was considered more appropriate in a confined consultation room in Britain.

Language is another area to be considered. The findings of this study suggest that community languages played a significant role in the cohesion and entrepreneurial activities of the overseas-trained South Asian doctors. Bilingualism was somewhat acknowledged and promoted in the old multicultural policy, whereas this has been diluted by the community cohesion policy framework, with more emphasis placed on having one common language. The findings of this study showed that languages contain social values and attitudes, cultural practices and social norms that the interviewees called upon in times of adversity, and drew enormous strength from. It is useful to have one national language, but English does not need to be the single predominant language of communication. Similarly other languages do not need to be confined to their own language communities, as evidence in this study shows that they have much to offer to a wider learning community.
8.4.3 Greater Recognition of the Role of Overseas-trained South Asian Doctors

This thesis has highlighted that there are a number of areas where greater recognition of the role of overseas-trained South Asian doctors is vitally important. For example, the extensive contribution that they have made in the provision of healthcare services in the UK, as well as their commitment to meet the needs of the most marginalised UK communities. There should be some acknowledgement of the much wider roles of overseas-trained South Asian doctors, instead just pigeon-holing them as culturally competent professionals.

The discussion on how racism is experienced by overseas-trained South Asian doctors highlights the significance of the need for the NHS to develop ant-racist strategies, policies and practices for the future. The findings strengthen Coker’s (2001, 2) argument that the NHS needs to understand the language, philosophy and practice of discrimination, their relationship with the underlying ideology of white supremacy and power, and then translate such awareness into their policies.

Policy development needs to take into account that professionals from BME backgrounds also need awareness-raising regarding diversity issues. A common assumption is that all BME staff have an increased awareness of diversity issues, whereas the findings showed that lack of institutional support around diversity issues can lead to individuals’ internalising negativity. It is important to recognise that they need to be supported before they can support themselves. One way forward is that more awards should be made available for individuals to undertake innovative work and enhance current equality and diversity training, inspiring the creation of positive role models. An example is the Mary Seacole development award that Pamela Shaw successfully used as the basis of a DVD to enhance current equality and diversity training; in particular from the angle of celebrating the contribution BME professionals have made to the NHS, and with the intention of
making these individuals more visible, and showing how they feel good about themselves and their service contribution (Shaw, 2010). Overseas-trained South Asian doctors, including those who are retired members, as well as a variety of other BME professionals from different occupational backgrounds could be approached with a view to getting involved in enhancing the delivery of Equality and Diversity Training, as they have a wealth of experiences in areas such as dealing with adversity, empowering others, and working with marginalised groups and not just BME groups, but people who lead from the heart, have passion within themselves, determination, and are also able to access opportunities. It would be helpful for them to provide others with stimulating environments, and share their vision and passion about what they have done. Sharing the reasons for their success with others on a face to face basis, rather than through one off computer-based e-learning, would be much more meaningful and effective at ensuring these patterns are repeated, and will inspire others to visualise their own career progressions.

The evidence in this study as discussed in section 7.3.5 Doctor-Patient Interaction showed how the interviewees had developed strategies to meet the needs of their diverse patient population and believed that they had been able to dismantle the power relationships that occurred with marginalised patients, in particular, white marginalised patients. Examples of good practice can be developed from further exploring in this area.

The interviewees talked about provision of healthcare which was sensitive to the linguistic and cultural needs of the Asian community, often in the absence of any particular direction from the NHS. There are, however, dangers in assuming that only Asian GPs provide high quality and culturally competent healthcare services. I argue this for two reasons. Firstly, the evidence in this study shows that the interviewees were often less sympathetic to the complexity of needs of exhibited by Asian patients, in comparison to white working class patients whom they regarded as less problematic. This may be related to the class
difference and how perceptions about social hierarchies globally exist in societies. Secondly, the evidence suggests that the majority of interviewees did not wish to be pigeonholed in any way and expressed a desire to offer their services to the wider society, rather than just a section of it. They very much believed in their professional ethos and viewed their role as universal. It is important to avoid the ghettoism that arise from a concentration in certain specialties, as this would limit their opportunities to work in ‘sought-after’ specialties, which have so far been predominantly white and will continue to be so (Esmail, 2001).

It is also important that policy makers recognise issues beyond the narrow use of domestic policies such as the community cohesion policy framework and the roles it prescribes for migrants within its limited definition (one national identity, one national language and British values), and the NHS only considering medical migration in relation to securing staffing levels nationally. Policy makers should consider the implications of global migration around healthcare and the gains that can be accrued by developing countries from the migration of overseas-trained South Asian doctors. Evidence strongly suggests that these individuals are in a prime position as medical diasporas to take on more transnational roles, magnifying the resources in the countries of their origin, where some of them are already involved as social entrepreneurs. However, these roles need to be legitimised with a view to maximising advantages that may be gained by means of human capital transfer and philanthropy when flows of expertise are potentially multiple and multi-directional, and whether it is temporary, virtual and/or in person. This will also have fewer implications for the sending developing South Asian countries, meaning the ‘Brain drain’ is thus replaced with ‘Brain Gain’. Domestic policies need to be developed in concordance with the obligations of international healthcare polices such as those of the World Health Organisation (WHO) which emphasises that health is a shared responsibility,
involving equitable access to essential care and collective defense against transnational threats.27

A final point I would like to stress is that the doctors in the study had a perception that they had been accepted as a legitimate and valued part of British society. This, I believe was to a large extent owing to the intersectionality of their professional, class and racial identities, which may not be afforded to others in circumstances where there is an absence of such overlapping elements. It is also important to remember that the doctors in the study were elites who were able to participate more fully in UK life than their non-elite counterparts because the structure of their lives gave them exposure to a wide range of people and situations such as interactions at work, with medical/educational professionals and patients and communities, this sometimes forced them to shift their reference frames as new skills were needed for them to be able to progress. They were instrumental adapters, whom Levitt (1998, 931) describes as able to alter and add to their routines for pragmatic purposes, able to readjust their frames of reference to equip them to better deal with the challenges and constraints of migrant life. However, the extent to which the interpretative frames of migrants are altered is very much a function of their interaction with the wider society, which also depends upon their socio-economic characteristics and the opportunity structures available to them (Portes and Zhou, 1993). I believe that institutions and governments should not be allowed to escape from fulfilling their responsibilities, and that they must play a role in ensuring equality of opportunities by eradicating entrenched disadvantages, rather than putting a disproportionate onus on the citizens themselves to achieve community cohesion. This study has consistently shown that while the elites in this study were in a privileged position as a result of their socio-economic background, and local structures offered opportunities through which they were able to embed themselves,

27 World Health Organisation
http://www.who.int/about/en/
feeling more included and valued leading to their successful career trajectories, eventually, however, they also experienced structural inequality as a result of their ethnicity.
Appendices

Appendix 1: Discussion Guide for Interviews

**ID Number:**
- Date of interview:
- Time of interview:

1) **Demographical Information**
- First of all I would like to ask a few questions about yourself and your family background.
- Age (date of birth?), Male/Female, Year of arrival in the UK, Country of birth,
- Country where you obtained your medical training?
- The position of your career when you left your country of origin?
- Can I ask you your marital status?
- Do you have a partner?
- What is the ethnic origin of your partner?
- What does your partner work as?
- Do you have any children?
- How old are the children?
- Is your family here with you in UK?
- Did your family have any problems coming to UK?

2) **Present Circumstances**
- Could you tell me what your current position is regarding work i.e. are you working/ semi-retired/retired etc.?

3) **Start up, Early to Middle Period**
- I am interested in exploring ‘why you left the country of origin’ and ‘why you came to the UK’?
- How much of a role did your family play in your decision to leave your country?
• Which countries did you consider and why did you choose UK over the other countries?

• Tell me about what expectations you had before you came here? What did you think UK could offer you (pull factors)?

• What happened from the point of exit from your country onwards in relation to settling in period, do you think you have met you expectation by coming to UK?

• How would you describe this period when you first arrived in UK?

• Did you move around a lot in the first few years?

• What infrastructures were/were not in place to ease adjustment process/ transition process?

• What difficulties, if any, did you encounter during this time? E.g. language barrier, communication difficulties, housing difficulties etc?

• Regarding your relationship with the NHS, how much contact did you have with the NHS and whether the NHS were helpful or not?

• At what point did you decide to make UK as your permanent home?

• How long after arrival to UK did you decide to go into General Practice? Was it your choice?

• What motivated you to go into such field? (E.g. blocked upward mobility, best use of expertise, discrimination, meeting the needs of minority communities, independence?)

• How did you enter General Practice?
  1) Setting up a new practice in an under-doctored area
  2) By applying in competition for an advertised vacancy
  3) By obtaining an assistantship with a view to partnership?

• What difficulties, if any, did you initially encounter in setting up the practice and how long did it take?

• How did you raise funds to establish the practice?

• How would you describe the process of accessing funds?

• How did you build up contacts with other GPs?

• How would you describe your relationship with local NHS and other GPs?

• What was your perception of what you were doing when working in rural/inner city deprived areas often scratching from scratch?
Social entrepreneurs need certain characters/skills to be successful, what key entrepreneurial characteristics/skills/competencies did you require to set up such an enterprise?

Did you bring those skills/competences with you, had family traits, or were they learnt on the job?

What factors would you say facilitated/inhibited towards success?

Did you mostly work with other GPS from similar ethnic background to yours and what were some of the advantages for doing that?

**4) Community Cohesion**

You bring with you lived experiences of community cohesion and I am interested in exploring what was happening around you at the time you were practising as a GP.

Do you feel you were accepted by the patients from all backgrounds? Or did this degree of acceptance vary among them?

What perceptions do you think your patients (White and BME) had of you?

Do you feel that you had to work harder in order to gain the confidence and respect of your White Patients?

What were your experiences like with patients from your own communities?

How did you deal with cultural competence issues?

What contribution, would you say you made, as a health care professional, towards meeting the needs of your white patients, in particular White working class patients?

What contribution, would you say you made, as a health care professional, towards meeting the needs of patients from BME background, especially South Asian patients?

Do you have any memories as to how media portrayed the role of overseas trained South Asian doctors at the time? Was it negative/positive?

Did you have any other roles in the wider community that you were serving or within your own community?

What perceptions do you think other professionals in your local area had of you?

What were some of your positive and negative experiences like with patients, other professionals?

People often have negative stereotypes about different race groups, were there any experiences where you realised that your role contributed towards myth busting in any way?
• Were you aware of any potential friction between different communities and how did you address them?

• Did your service delivery model do anything specific to promote positive contact between people of all backgrounds?

• Did anyone else in your opinion facilitate positive interaction among different groups at the time or did any work to build bridges between communities?

• Do you feel that you had to lose some aspects of yourself in order to be accepted by the ‘host’ community?

• Do you feel that you were forced to adapt to fit/integrate in the system in any way?

• Do you feel your job affected your social identity? Do you feel you had to make significant sacrifices i.e. friendship and relationships etc?

• How did you maintain your plural/multiple identities as British, professionals from South Asian, Hindu/Muslim/Sikh/Christian/Parsi background? Did this present conflict in your day to day living?

• Some anecdotal evidence suggests that South Asian doctors became accustomed more with the British way of life and mixed more with the White community than their own community. Do you feel that by adapting in this way in order to survive in two different worlds is the right strategy and whether this approach is likely to have had a negative effect on those individuals concerned?

• Did you live in the same area as your practice was or lived in middle class White areas?

• What were your experiences living in predominantly White middle class areas? Did you have opportunities to socially interact with others of different culture and religion, if so on what level?

• Did you feel you had acquired a sense of belonging?

• What helped/did not help re enhancing a sense of belonging?

• What were your own personal experiences like raising your own children in UK, with public services i.e. education system and health services etc?

• What were your own family experiences like within the UK, (as a citizen, public services, health services etc)

• How were your experiences with the education system,

• How did your partner and children adapt to life in UK.

5) Links

• Tell me a little about the links that you had with other professionals as well as professional bodies such as GMC, BMA and NHS?

• How effective would you say they were, did you feel supported?
• How would you describe your relationship with local PCT in relation to finance and administrative matters?

• What were your main support networks, mainstream or your own informal networks and what was your choice based on?

6) Role played as Professionals

• What role did you play regarding meeting the needs of black and minority communities (BME) communities in relation to culture, religion and language?

• Would you say that the way you practiced medicine was unique as a result of your particular cultural background and training undertaken in the Indian-sub continent, if so can you describe how it differed from your counterparts in UK?

7) Role played in Country of Origin

• It is often assumed that migration of highly skilled workers leaves the sending countries with brain drain. Have you provided any form of practical/educational/financial support to the country of your origin during the time you have been in this country?

8) Reflections

• Reflecting back on your experiences, what insights have you gained in relation to the following?

• Migration and career progression

• Links with BMA and other professional bodies

• How you fitted in, barriers that you faced/discrimination/racism?

• Did you feel valued for what you did and by whom?

• Did you feel that you received recognition for all your roles that you performed simultaneously in the community?

• Earlier on I was talking about your family and children, can you tell me if any of your children also followed into medicine and how different are things for them or British born South Asian doctors?

• What do you think you have learnt from working as a GP in Britain?

• Is there anything else that you feel is important but I have missed out on?
Appendix 2: Definition of Racial Harassment Used in Interviews

Box 8.1 sets out the definition of racial harassment developed for NHS employers, which included examples of racially harassing behaviours.

**BOX 8.1 DEFINITION OF RACIAL HARASSMENT**

Racial harassment is unacceptable targeted behaviour motivated by racial intolerance affecting the dignity of women and men at work.

Racial harassment covers a wide range of unacceptable, and often unlawful, behaviour. There are the more obvious and overt forms of harassment such as racist language and physical intimidation. However, racial harassment is frequently more covert. These more subtle forms of racial harassment, such as deprecating the way people dress or speak, are equally distressing and can create an intimidating and unpleasant atmosphere at work.

Examples of racially harassing behaviours include:

- patronising remarks
- shunning or excluding people from normal workplace conversation or social events
- being condescending or deprecating about the way people dress or speak
- intrusive questioning about a person’s racial or ethnic origin, culture or religion, or subjecting this to mockery
- unjustified criticism of work performance
- unfair allocation of work and responsibilities
- racist ‘jokes’, banter and insults
- display or articulation of racially offensive material, including racist graffiti
- denial of access to training and/or overtime
- black and minority ethnic staff being more likely to be disciplined than white staff
- threatening and abusive language
- physical abuse or intimidation.

Racial harassment may be deliberate and conscious, but it can also be unintentional, as when an individual is oblivious to another person’s feelings and sensitivities.

Source: Collins (2001, 171) in *Racism in Medicine*. 
Appendix 3: Information Sheet for Interviewees

Identity, Migration, Community Cohesion and Healthcare:
A Study of Overseas-trained South Asian Doctors in England and Wales

Information Sheet for Participants

You are being invited to take part in a research study. Please ask if there is anything that is not clear or if you would like more information.

Who will conduct the research?

G Yasmin Farooq, CCSR, The School of Social Sciences, The University of Manchester, M13 9PL UK

What is the aim of the research?

The aim of the research is to gain an insight into the experiences of South Asian overseas trained General Practitioners, as to how they were mobilised within the UK health care system and what contribution they believe they have made from their arrival as highly skilled migrants. It is anticipated that the findings will inform any future service planning in various settings such as the health care sector and in the area of community cohesion.

Part of the research will involve collating statistical information on the total number of General Practitioners from the Indian sub-continent working in the NHS over time and detailed information about their demographic characteristics and geographical location by accessing information from the General Medical Services’ (GMS) workforce dataset. This will be followed up with a series of interviews with doctors who worked as GPs from 1980 onwards, some of whom may well have retired by now. The key research questions will be related to the GP’s experiences of migration, mobilisation in the NHS, entrepreneurship and community cohesion in the UK.

Why have I been chosen? There will be around 50 interviews of General Practitioners who are overseas trained and of South Asian background. You have been chosen as you are from the above background and have been identified by a friend or an organisation as someone who may be interested in taking part in the research.

Why have I been chosen? There will be around 50 interviews of general practitioners who are overseas trained and of South Asian background. You have been chosen as you
are from the above background and have been identified by a friend or an organisation as someone who may be interested in taking part in the research.

**What would I be asked to do if I took part?** Participation in the research will generally involve taking part in one or two interviews which will be arranged at a time and place most convenient to you. The interviews will last between an hour and a half to two hours, and will explore your experiences of migration to the UK, contribution to the NHS as a General Practitioner and your role as an entrepreneur. The interviews will normally be recorded with your permission. The recording, or part of it, will then be transcribed.

**What happens to the data collected?** Confidentiality of participants will be maintained and their data protected. Names and addresses of participants, digital copies of interviews and ID numbers for hard copies of interviews will be kept on a password protected computer. Permission will be sought to attribute quotations as and when appropriate and this will be included in the consent process. The interviewee material will be used in publications, however, if permission for future use of the data is declined by the participants, this will be respected and the interviews and other material will be destroyed after the completion of the proposed study. The findings from the research will be completely anonymous.

**How is confidentiality maintained?**

As above.

**What happens if I do not want to take part or if I change my mind?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself.

**Will I be paid for participating in the research?**

There is no agreement for payment to the participants.

**What is the duration of the research?**

The interviews will last between an hour and an hour and a half,

**Where will the research be conducted?**

The interviews will be conducted in participants’ own homes or a mutually agreed venue.

**Contact for further information**

If you would like further information or if there is anything in this sheet you would like to discuss, please do not hesitate to contact

Yasmin Farooq

Doctoral Student, School of Social Science, CCSR,
Appendix 4: Consent Form for Interviewees

Identity, Migration, Community Cohesion and
A Study of Overseas-trained South Asian
Doctors in England and Wales

CONSENT FORM

If you are happy to participate please complete and sign the consent form below.

Please initial boxes.

<table>
<thead>
<tr>
<th>I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to any treatment/service</td>
<td></td>
</tr>
<tr>
<td>I understand that the interviews will be audio-recorded</td>
<td></td>
</tr>
<tr>
<td>I agree to the use of anonymous quotes</td>
<td></td>
</tr>
<tr>
<td>I understand that the findings from the research will be completely anonymous.</td>
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<tr>
<td>I agree that any data collected may be passed to other researchers</td>
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I agree to take part in the above project

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<table>
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Appendix 5: Demographics of Doctors in the Study

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<th>Country of qualification</th>
<th>Sex</th>
<th>Yrs of experience as a GP</th>
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Major Urban MU
Large Urban LU
Rural R
Appendix 6: Poster Presentation at the British Sociology Annual Conference 3rd-5th April 2013

Community Cohesion and Healthcare: A Study of Overseas-trained South Asian Doctors in the UK

In the last decade or so, community cohesion in Britain has been an issue of concern in which the role of migrants in the UK has been scrutinized in the context of their sense of belonging and contribution.

This paper presents findings of an empirical study of overseas trained South Asian doctors in the UK who have made a substantial contribution in the National Health Service. A mixed method and a case study approach that includes a secondary data analysis of the UK General Practitioners workforce statistics and in-depth interviews with 27 overseas trained South Asian doctors in three case study areas to capture the diversity of experiences is employed to examine the nature and extent of the contributions of this highly skilled group of people, the social roles that they have played in the wider society and how they have dealt with the challenges as migrant professionals and utilised opportunities. The key themes covered were community cohesion, migration experiences, identities and mobilisation patterns of doctors in the National Health Service.

The driving force behind the migration of overseas trained south Asian doctors was their motivation to come to UK for post graduation qualifications; however, upon arrival to the UK, they experienced marginalisation due to institutional racism that erected structural barriers at a societal level. Their accounts provide evidence of being channelled into temporary and low specialty jobs with little or no prospect of career progression. Their accounts reveal that they used structure and own agency to overcome blocked social mobility and entered into general practice. The findings show that the entrepreneurial behaviour of these highly skilled migrants had resulted in a parallel process to that of their low skilled counterparts.

http://www.britsoc.co.uk/media/50981/AC2013_Full_Prog_Web2.pdf
Interactions Between Marginalised Patients and Marginalised Doctors – A More Reciprocal Relationship?

Abstract

While different theoretical perspectives on doctor-patient encounters have been put forward, what is agreed among sociologists is that medicine acts as an important institution of social control (Lupton, 2003). Nearly all theorists on the doctor-patient relationship have described the way in which powerful groups in possession of medical and scientific knowledge have been privileged over others. Criticism of these standard theories have centred on their tendency to focus on the micro-properties of interactions of doctors and patients rather than incorporating an analysis that includes the macro-level social and political context within which such encounters take place. Almost all existing studies focus on the powerful positions that the medical practitioners hold and portray patients as disadvantaged in one way or the other.

This paper examines the empirical evidence from a study that involved in-depth interviews with 27 overseas-trained South Asian general practitioners in diverse geographical contexts in the UK. The findings show that the standard theories concerning socio-cultural dimension of western medicine do not fully reflect the experiences of overseas-trained South Asian general practitioners in their interaction with patients. The asymmetry in power relationships in the clinical discourse is reversed when this encounter is between a white patient and an overseas-trained South Asian migrant doctor as both bring an imperial element into the encounter. The specific UK contexts serve as spaces where identities of practitioners and patients are simultaneously negotiated against a backdrop of the legacy of the empire. The insights into their relationships show that they are more of a reciprocal nature than of medical dominance.

http://www.britsoc.co.uk/media/54364/MedSoc13_Abstract_Summary.pdf
Appendix 8: Joint Paper Presentation in XVI World Congress of Psychiatry, Madrid, Spain, 18th September 2014.

Symposium Title: Beyond Borders: Global Challenges and Solutions in Medical Migration

International medical graduates and the making of a specialty: South Asian general practitioners in the UK’s National Health Service

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This paper explores the role of migrant doctors from the Indian subcontinent in the development of the specialty of general practice in the UK’s National Health Service (NHS). It questions traditional views of medical migrants as simply supplementary labour and looks at the extent to which they can be seen to have a specific and transformative impact on the provision of healthcare.

The conclusions presented here are based on two separate studies. One used oral history methodology to explore the life stories of 40 South Asian doctors who worked as GPs in the NHS between the 1940s and the 1980s. The second investigated socio-economic and socio-cultural integration experiences and perspectives of overseas-trained South Asian doctors. A mixed method approach was employed that included secondary data analysis of the GP Workforce Statistics and in-depth interviews with 27 overseas-trained South Asian GPs.

This work shows that migrant doctors were not only supplementing the UK GP workforce, they were taking on particular healthcare roles and in a position to exert agency. They clustered in areas of high need, and shaped their profession through the adoption of distinctive approaches to their work.

These findings have implications beyond general practice and beyond the context of the UK in light of the international patterns of concentration of medical migrants in particular specialties, including psychiatry, as well as in less affluent localities. They point to the need for a greater appreciation of the specific function of migrant doctors in healthcare systems in the Global North. Reflecting on the nature of their contribution to the development of healthcare can enhance our understanding of the nature of healthcare provision.

http://www.tilesa.es/wpamadrid2014/abstracts/volume7/#/238/
Appendix 9: Sibéal Annual Conference Gender and Metamorphosis

Identity experiences of elite overseas-trained South Asian doctors in the UK

Trinity College Dublin, 21/22nd November 2014

(Ghazala Yasmin Farooq, The University of Manchester)

This paper examines the empirical findings from a doctoral study that involved in-depth interviews with 27 overseas-trained South Asian doctors practicing as general practitioners in three geographical locales with varying ethnic density and urban/rural mix in the UK. The study set out to explore the migration trajectories and how this group of elite migrants integrated into the UK society, perceived their identities and whether they had acquired a sense of belonging to Britain. The findings show complexity of issues involved as the doctors in the study navigate their multiple identities in the UK context such as post colonial identities, elite migrants, denial of racism and how race, class and gender intersect against a backdrop of pre-existing colonial relationships in urban and rural geographical locales.

The doctors integrated into the medical world, as a ‘professional diaspora’ and creation of a collective identity of these physicians owed its existence not to the traditional ethnicity denominator which is considered imperative for the creation of diasporic communities, but rather from other forms of shared values and meanings, that is, from a shared professional identity. They used their professional identity which served as symbolic capital and protected them from experiencing racism.

The findings show that the standard theories concerning socio-cultural dimensions of western medicine do not speak to the experiences of overseas-trained South Asian general practitioners and the asymmetry in clinical discourse is in reverse when this encounter is between a white patient and an overseas-trained South Asian general practitioner as both bring an imperial element in the encounter.

Bibliography


Beagan, B. L. (2003) Teaching Social and Cultural Awareness to Medical Students:" It's All Very Nice to Talk about It in Theory, But Ultimately It Makes No Difference". Academic Medicine, 78(6), pp. 605-614.


Lazarsfeld, P. F. (1972) *Qualitative analysis; historical and critical essays*: Allyn and Bacon.


Navarro, V. (1978) *Class struggle, the state and medicine: an historical and contemporary analysis of the medical sector in Great Britain*: Martin Robertson.


