

Migrant clustering: the role of patronage networks in South Asian medical migrants' labour market participation in the UK

Joanna Bornat, Leroi Henry, Parvati Raghuram

Paper presented at: 'Mobility in International Labour Markets': Joint Conference of Bristol University's Centre for the Study of Ethnicity and Citizenship and UCL's Migration Research Unit, 15-16 May, 2008, University College London, UK

Not to be quoted without permission.

Address for correspondence:

Joanna Bornat (j.bornat@open.ac.uk)

Leroi Henry (l.w.henry@open.ac.uk)

Parvati Raghuram (p.raghuram@open.ac.uk)

Introduction

There has long been considerable interest in social networks and their role in migrants' labour market outcomes in countries of destination (Bonacich, 1973; Boyd, 1989; Poros, 2001). This literature has explored the ways in which social networks have enabled, or sometimes limited migrants' labour market participation in waged work (Smith et al., 2006; Vertovec, 2002), self-employment (Kloosterman and Rath, 2001; Anthias, 2007), in skilled sectors of the labour market (Findlay, 1990; Xiang, 2001; Meyer, 2001) as well as in lesser skilled sectors of the labour market (Shah and Menon, 1999). Together this work has outlined a range of possible outcomes for how migrants get access to jobs, achieve career mobility and social mobility and also how the lack of access to such networks in the post-migration scenario can lead to lack of access to appropriate career opportunities, inadequate career progression and sometimes to niche labour markets with stultified opportunities. Yet, despite the diverse range of studies thus far conducted around this topic, most studies explore migrants' networks as separate entities: as networks that are shared by migrants from similar areas of origin or ethnic ties (Anthias, 2007). Hence, ethnicity often provides an implicit or explicit boundary for defining a meaningful network within a labour market context. Underlying the treatment of migrants' networks in isolation is a notion of migrant as 'other', as distinctive and unrelated to non-migrants and their networks. There is little work on how migrants fit in, rework but also sometimes get excluded from existing networks which may contain migrants as well as non-migrants.

This distinction between migrant and non-migrant networks is also reproduced in the literature on non-migrants' social networks with little discussion of migrants' participation in such networks. Thus, interesting studies that trace the role of social networks in shaping non-migrants' access to labour markets (Smith & Nicolson, 2007) do not discuss how migrants may have experienced or participated in such groupings. Rather, most of the emphasis focuses on how networking might form the basis for converting social capital to other forms of capital (Bourdieu, 1986) without exploring how these forms of capital may be accessed or converted by non-migrants. The role of non-migrant professional networks in shaping migrants' labour market experiences has, for instance, rarely been discussed. In this paper we aim to address this gap by exploring some issues posed by the wider literature on social networks of migrants through an analysis of how migrants have negotiated professional networks to which they may partially or temporarily belong in the UK.

Patronage and the role of patrons are key factors in the management of movement out of and into different migration contexts. Patronage may facilitate, generate or obstruct the functioning of migrant networks, it may work across international boundaries, professional barriers and institutional structures, and it may also work within all these. Combined with networks, patronage may provide a mapping of opportunity and support agency on the part of migrants. It may also at times be a false friend, and a relationship which carries with it, its own ambiguities.

In this paper we look at some of these issues as they lead to a much more nuanced story of labour market participation. We explore networks and patronage amongst skilled migrants within their specific temporal and spatial contexts, viewing how the power effects can be traced through the connections that migrants can or cannot make in the complex landscape of networks that professional migrants inhabit. These connections can be both facilitative and inhibitive to social mobility. We also explore how ethnic and occupational hierarchies intersect within these networks and some of the structural forces that constrain the effectiveness of networks.

As a means to uncovering the strategies and responses adopted by migrants in pursuit of professional advancement this paper draws on oral-history interviews conducted with overseas-trained¹ South Asian doctors who joined geriatrics in the last 40 years. While statistics of movement, recruitment and professional progression provide evidence of the presence of South Asian doctors in the UK's health system, they only tell one part of the story. How these doctors experienced, made use of and made and adapted networks, identified and were identified by patrons can only emerge from interview data. In an ESRC funded project² using oral history as its primary research method, we aim to collect 60 interviews with retired and serving geriatricians by the end of 2008. Geriatrics offers us an interesting site to explore issues as they relate to networks because although doctors are highly-skilled and relatively well-paid, geriatrics is seen as a marginalised area of medicine within the spectrum of medical specialties. With a relatively high preponderance of South Asian doctors, it came to be regarded as a 'brown skinned specialty', making it ideal for an exploration of the relationship between migrant and professional hierarchies.

The rest of the paper is divided into four sections. The next section explores some of the literature on social networking and migration and identifies some lacunae in the existing literature. The section which follows provides a discussion of the contribution of oral history to migration studies. The penultimate section discusses some of the complexities of networks as they pertain to migrant doctors while the last section provides a conclusion.

Social networks and labour markets

Social networks have been used as an analytical frame for understanding migration for some time. Their strength lies in the fact that by emphasising the role of agency and aspects of the social which condition agency during the migration process (Boyd 1989) networks partially overturn the unhelpful distinction between agency and structure. In doing so they expand the notion of chains of migration which had long been a way of understanding migration (Dicken et al., 2001). In a network analysis 'structural factors provide the context within which migrant individuals and groups make decisions. However, at this micro level analysis, the decision to migrate is influenced by the existence of and participation in social networks, which connect people across space' (Boyd 1989: 645). They help to sustain migration flows by providing information, accommodation and employment for incoming migrants and thus serve as an important link between the individual actor and the structural context that fashions migration flows. Once migration begins these

networks come to function as causes of migration in themselves because they lower the costs and risks of migration and increase its expected returns (Massey et. al 1993). They thus help us to combine accounts of structural context (in which structure is seen as both constraining and enabling) with situational, micro-level understandings.

The nature of the network may vary and include familial networks, kinship networks (Raghuram 1999), hometown associations (Henry and Mohan 2003), professional networks such as alumni (Vertovec 2002), entrepreneurial networks (Ong 1999; Campani 1994), religious networks (Hüwelmeier's 2001) and so on. These networks not only shape migration streams but also become an independent variable so that for Massey for instance, ' the international flow of migrants becomes more and more institutionalised and independent of the factors that originally caused it (Massey et. al. 1993: 451). The institutional arrangements that shape migration are best taken into account through the notion of channels of migration (Findlay, 1990). This notion of 'migrant institution' represents a significant advance, in providing an account which can deal with the myriad agencies and organisations now operating in the 'business' of migration, organisations that have developed to support, sustain, and promote movement. They act as channels of migration shaping networks.

Networks are also inscribed with power differentials between those who have achieved some stability and upward mobility after migration and those who have not. Class and gender hierarchies too play their part in shaping participation in social networks so that social networks may be used both to exploit (Hondagneu-Sotelo 1994) as well as to support (Robinson 1991) other migrants. Below, we explore two aspects of the literature on networks as they relate to our empirical case study. As our interests revolve around the presence of large numbers of South Asian trained doctors in the geriatric specialty, we focus on networks as they relate to skilled migrants, and networks' role in migrant clustering in segments of the labour market. These reviews of the literature do not aim to be comprehensive, but rather try to suggest some avenues where existing discussions have been less than full and how our research contributes to current ways of thinking about networks at the intersection between clustering and skilled migration. In what follows, we look at two specific aspects of migration networks: those relating to skilled labour markets and clustering as an effect of networking.

Skilled labour migration and social networks

One pertinent literature where some of these issues around social networks are addressed is that on skilled labour markets. Initially, much of this literature was conceptualised within the theoretical framework offered by globalisation theories, where the movement of skilled people is tied to the rapid growth in the movement of goods, services, information and capital. Studies focusing on the migration of skilled personnel employed in transnational financial corporations have dominated this literature (Koser and Salt, 1997). These studies are theoretically and analytically linked to the large and growing literature on globalization. Skilled migration involves the movement of people as actors facilitating and regulating flows of money and goods in an

increasingly interdependent world (Beaverstock, 1994, 1996). The focus of much of this literature has been on the movement of people within and between the capitalist core countries whose flows were unfettered through immigration policies or through racial discrimination. The research spotlight has been on global elites whose transfer from country to country was eased through corporate transfer arrangements. There was little on ethnic disadvantage as most migrants were seen to be white.

Here too social networks came to be seen as important for accessing jobs (Vertovec, 2002; Xiang, 2001), for the success of capitalist ventures and for social adjustment within expatriate 'bubbles' (Beaverstock, 2002). While some such studies focused on waged employment in the corporate world, others highlighted the role of networks in business enterprises (Greve and Salaff, 2005) with a separate literature on migrant business people and their networks. Together they are seen as key agents of globalisation (Vertovec, 2002). According to Favell et al (2006), these people are stylized as 'elites' in contrast to the disadvantaged, ethnically distinct class of migrants to which they are counterposed. Even where migrants are working in waged employment, migrant channels are seen as supportive of migrants' entry into the labour market (Findlay, 1990).

Although networks are often seen as facilitating flows of capital and people, there has also been increasing recognition of the limits to the extent to which such networks can be mobilised by different groups. The difference that both gender and ethnicity make to the circulation of skilled migrants is slowly coming to be recognised (Raghuram and Kofman, 2002; Nagel, 2004). Canadian and Australian research has shown how female and male migrants were not able to overcome gendered and racialised disadvantage despite having skills (Salaff and Greve, 2004; Ho, 2006; Girard and Bauder, 2007). Social networks seem to have broken down in the post migration scenario, limiting people's access to the labour market. In the UK context Smith et al. (2006) reported perceptions amongst some nurses and managers that strong social networks could inhibit individual upward social mobility, i.e. that networks can impede career progression.

However, on the whole the treatment of networks in skilled migration literatures emphasize the productive possibilities of migration, rather than highlighting how networks limit the opportunities available to some parts of the population. In particular, it rarely looks at networks that are already in place in destination countries and how migrants insert themselves into networks which are not based around migration, but around professional affiliation, neighbourhoods and other forms of sociality. These and other points provide a focus for our study of South-Asian overseas trained geriatricians.

Networking effects: Clustering

A second and related body of work for us is that which focuses on one effect of social networks in migrants' labour market participation: clustering. Clustering is seen as the effect of social networks that channel migrants into specific parts of the labour market and is seen to have mixed effects on migrants. Economists in particular have conducted large multivariate studies

on occupational clustering. For some, clustering can be seen as a manifestation of labour market discrimination, whereby migrants find jobs in the few sectors of the labour market that are open to them. This form of clustering was explained in the 1970s through a Marxist analysis of labour market segmentation – primary market with better wages; secondary market with temporary labour on lower paid wages (and see Colic-Peisjer, 2006 for a discussion). Subsequently race was seen as working alongside class to segment labour (Reid and Rubin, 2003).

A series of fine ethnographic research studies have also shown how clustering is an effect of how people negotiate networks (Elliott and Lindley, 2006). Some studies reveal how clustering is about people's agency within the context of labour market discrimination. Still other studies suggest that clustering is an effect of the social capital that migrants possess – they are able to network in order to get access to particular kinds of jobs (Schrover et al., 2007). These studies increasingly differentiate between immigrant clustering where all immigrants cluster and ethnic clusters where people from one ethnic group employ others from the same ethnic group.

Despite these variations, certain key features of existing research on clustering are also identifiable. For instance, given the interest in clustering as a marker of disadvantage, most of the literature on labour market clustering focuses on entrepreneurship or on employment in lesser skilled sectors of the labour market such as domestic work (Kloosterman and Rath, 2003). They also tend to look at ethnicisation as a process 'whereby an association develops between a certain economic sector and an ethnic group.' (Schrover et al., 2007: 535).

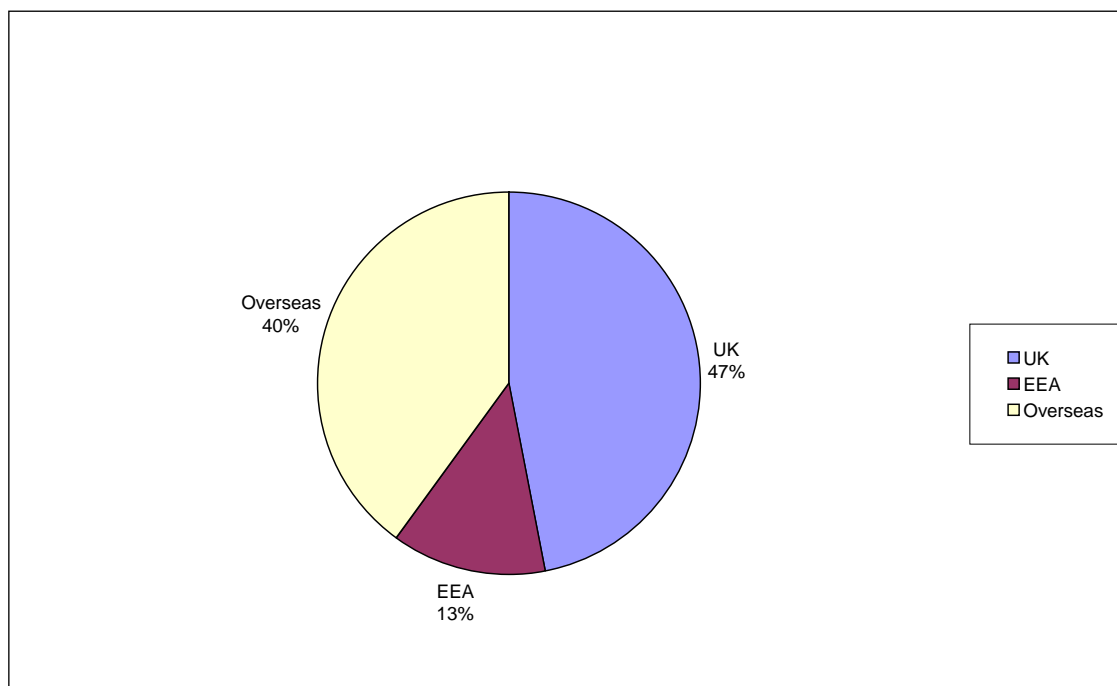
There is little in the literature on ethnic clustering as a process that marks migrants in skilled sectors. Yet as we will show below, ethnicisation is also a process of importance for highly skilled migrants. Clustering also rarely appears as a marker of labour market success. Social networks that lead to clustering can be seen as disadvantageous both to labour market integration and to social mobility (Smith et al., 2006). However, the terms and basis of social mobility and labour market integration are not often interrogated. As a result the nature of networks, the form of clustering and the shifting status of a labour market niche within narratives of success may be ignored. The basis on which success stories can be narrated may also remain unquestioned.

Our research

In this paper we focus on how migrants are positioned within overlapping migrant and non-migrant professional networks and the effects of these network engagements in shaping labour market outcomes amongst a group of highly skilled migrants. We explore the issues faced by South Asian doctors who are ethnically marked both through their race but also through their countries of qualification (Anwar and Ali, 1987; Coker, 2001). Migrant doctors were, since the inception of the National Health Service, seen as an integral but devalued part of the health workforce. They were necessary for its operation, providing a mobile army of labour in the lower rungs of the medical hierarchy but were systematically disadvantaged in terms of access to jobs,

career mobility, the places where they found employment and the specialties they could occupy (Kyriakides and Virdee, 2003). The fact that in 2003 only 17 per cent of South-Asian doctors were consultants compared with 42 per cent of white doctors (Decker, 2001: 34; Department of Health, 2004) provides some evidence that migrant doctors from South-Asia found their careers limited by the institutionally racist and hierarchical nature of the NHS (Essed, 1991; Esmail & Carnall, 1997; Hutton, 2001). It is in this context that geriatric medicine became a refuge for many of them when they found they were able to make progress (Bornat, 2004; Goldacre et al., 2004).

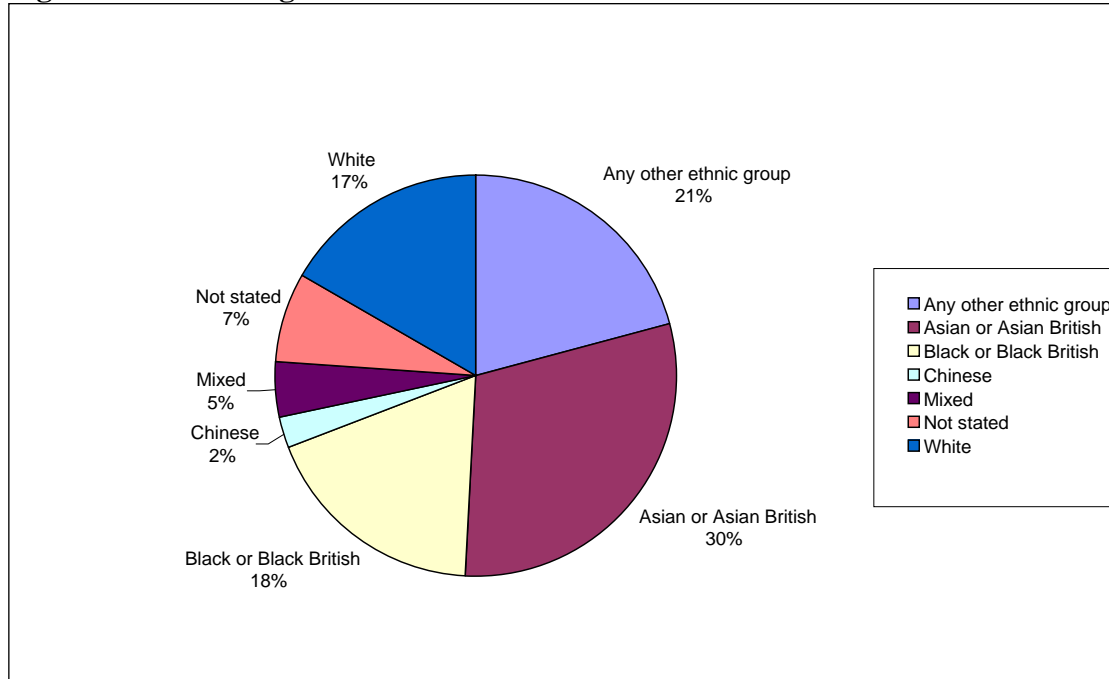
Figure 1: Consultant Geriatricians 2004 by place of qualification



Source: Department of Health, Statistics on Medical Workforce in England 2005¹

¹ The recording of medical workforce statistics varies between the four nations of the UK so data are not comparable. The General Medical Council's register of medical practitioners is the only source where data can be broken down to country of qualification. However, the register may include retired members as well as those not currently practising in the UK. Hence, the best way of estimating figures of South Asian trained doctors is to interpolate ethnicity figures with figures of those who qualified outside the EEA.

Figure 2: Ethnic origins of overseas trained Consultant Geriatricians 2004



Source: Department of Health, Statistics on Medical Workforce in England 2005

Since its inception, geriatric medicine has been a 'Cinderella specialty' (Smith, 1980; Jefferys, 2000; Thane, 2002) with one of the least regarded groups of patients: frail older people (Evans, 1997). As such, geriatrics came to be a field where South Asians easily found jobs so that 22 per cent of all geriatric consultants appointed between 1964 and 2001 were non-white and had trained outside the UK, compared to 14.1 per cent of all consultants in the NHS (Goldacre et al., 2004; Figures 1 and 2, Table 1). One key aim of our research is to investigate to what extent these South-Asian doctors not only helped the NHS to care for frail older people but, through their membership and leadership within the British Geriatric Society (BGS) as well as other medical organisations, also contributed to shape the discipline in the UK.

Migrant doctors working in the geriatric specialty typify an example of operating within a secondary medical labour market, despite their skills. By looking at the complexities of the formation of skilled labour markets, we can also see that narrations of career success and of career mobility cannot be treated as given for skilled migrants. Geriatrics, thus offers us an ideal point to explore the relationship between ethnic and professional hierarchies.

Methods

The South Asian overseas-trained doctors project is using oral history as its primary research method. With a target sample of 60 interviews, sixteen averaging two hours each in length have been completed, eight having been transcribed. This paper draws on the first eight transcribed interviews, a group which includes doctors trained in India, Sri Lanka, Pakistan and Burma,

ranging in age between 40 and 75. The sample will eventually include doctors whose careers ended at different points in the medical hierarchy. However, the interviewees whose accounts we draw upon for this paper all happen to be consultants and some also held academic posts such as that of professors.

Interviewees are being recruited through networks of overseas doctors (British Association of Physicians of Indian Origin for example), the British Geriatrics Society and through snowballing as the project progresses. The interview schedule uses a life history approach, asking participants to talk about their childhood, upbringing, education at school and college and subsequent training and careers in their home countries and after arrival in the UK. The doctors are asked about their reasons for migration to UK, arrival and subsequent career progression in the UK with a focus on opportunities, barriers and sources of support. All the interviews will eventually be transcribed and deposited in the British Library (unless specified otherwise by participants) where they will sit alongside an earlier study of UK born pioneers of the geriatric specialty carried out by Professor Margot Jefferys and colleagues in 1990-1.

The choice of oral history as a method in migration studies is well-attested, as we will go on to show. Both as an approach and as a source of evidence, interviewing leads to rich and more greatly nuanced theorising as well as adding directly to knowledge of particular migrant experiences. Similarly, migration has been a central theme in oral history research for many decades, traditionally connecting back to early studies carried out under the aegis of sociology's Chicago School and Thomas and Znaniecki's seminal study of letters written by Polish migrants to the US (1927). More recently, the particular benefits of forging a link between geography, migration studies and oral history has been argued in an article which calls for a biographical approach to understanding migration (Halfacree & Boyle, 1993). As Chamberlain and Leydesdorff argue, oral history not only adds to knowledge of the migrant experience, but with a focus on memory, 'and its role in the continuing emotional adjustments in which most migrant experience is embroiled and implicated' oral history has itself benefited from the added complexity (2004, p. 228). As for oral history, so too for migration studies one would hope.

In a comprehensively written article, published in 1999, Al Thomson reviews oral history's contribution to migration studies over the previous twenty five years. In what follows, we draw on that paper as a starting point, noting achievements but also drawing attention to some limitations in existing migration oral history.

Thomson identifies aspects of oral history as an approach pointing to established markers within the literature. Following Paul Thompson he argues that oral history is revealing of a 'hidden history of migration' (1999, p. 26) that with a focus on trends, waves, flows and policies, personal experiences tends not to be brought into the picture. For example, he shows how knowledge of the functioning of social networks is brought out more clearly once the

members of supportive social circles are identified and particular contacts are maintained over time and space. He points out the way migrants' accounts illustrate how knowledge is used within family and communities, with stories of success and failure helping to explain, ease or mask challenges, transitions and failures in journeys and destinations. He stresses the importance of networks of relationships developed from family ties, across space and time, citing examples from the literature of studies showing the significance of 'Long-established migratory traditions' as 'motivational forces' (1999, p. 28). He points to the ways in which oral history can show how, for example, stories of a family's migratory history evolve, emphasising the 'complexity and contextuality of identity construction'.

Thomson illustrates how the cultural life of migrant communities may be delineated through accounts which include references to language, literature, religious observance, celebration and 'the complex interplay between introduced, minority cultures and the dominant practices of the host society' (1999, p. 29). How people felt about migration and migrant status becomes accessible through interviews which draw on past experience. Subjective experience, 'knowledge, feelings, fantasies, hope and dreams' (1999, p. 29) may be expressed through stories which explain transitions, opportunities and events in a migrant's journey.

Thomson's delineation of the contribution which oral history makes to migration studies matches our own commitment and intent, but only takes us part of the way. What is lacking in the literature is a perspective which is inclusive of the skilled migrant.

In keeping with its own radical and political development, oral history's exploration of migrant history focuses on underprivileged, unskilled, deracinated, ethnically cleansed, dispossessed, economically or politically forced migrants. And quite rightly too. Demographically and politically these form the greatest proportion of people moving to live in locations new to them. Indeed there is a large, and recent parallel literature which has been produced and disseminated by members of migrant communities whose aim it to tell the story of migration, both forced and chosen. Funded by lottery and other sources, these local projects draw primarily on first hand experience and have made a considerable contribution to awareness of migration as a personal experience³. However, by not paying attention to skilled migrants we may miss out on dimensions of movement from place to place which illustrate aspects of the migrant experience which have significance for change and adaptation across a wider cross-section of society, thus deepening understanding the interplay of migration and class.

For example, the focus on labour and finding work, central to most migrant stories, is linked inextricably to family and social networks of support and contact. Isabelle Bertauz-Wiame's early study of French internal migration identifies the role of family and friends in smoothing transitions on the way and into Paris (1979) while Warren D Anderson shows how family and community ties and identifications migrate with people in his study of workers who move from the Mexican state of Michoacán to Mexico (2001). In contrast,

family and community may play a much lesser role in the lives of skilled migrants. Though they may provide the initial starting point, the route into professional employment and the commitment to extending education and training, family and community are less likely to function after arrival as a lever into continuing employment for these migrants. Their stories are more likely to point to the creation of social networks, the identification of patrons and ways to maximise the value of a particular skill. Their professional identity is a commodity which they seek to trade and whose value they seek to maximise through both formal and informal means. In the case of South Asian overseas-trained doctors, this identity is defined within an employment structure which is internationally recognised and formally delineated: the National Health Service and organisations of the medical profession working within it. An oral history approach enables an exploration of the ways in which the formal and publicly visible characteristics of the NHS were managed and engaged with, informally, as this particular group of doctors sought their way in, and upwards.

Given a focus on inequality and difference defined in terms of ethnicity and culture, perspectives determined by class tend to be given less attention. Class does, of course, play a significant role in confirming marginality and opportunity for the poorest and least well resourced migrants; however, there is more than one story to be told about the effects of class. For the skilled migrant, the internationalisation of class as a variable becomes more complex, even more so for migrants from post colonial societies in South Asia. Assumptions as to the transferability of privilege will be subjectively questioned, judgements relating to performance, career expectations and hierarchical positioning will be unexpectedly shaded by mutually discordant histories and experiences of colonialism, race and the professional practices. All these are aspects of the skilled migrant's experience that collectively shape and determine an understanding of class and status positioning. By focusing on professional trajectories, linked to events and histories of family and community, it is possible to draw out these more nuanced and subjective understandings of migration amongst more privileged and skilled workers.

In the oral history literature, migrant stories of success and failure are discussed in relation to family myths, with examples drawn from African Caribbean families (Chamberlain, 1994; Bauer & Thompson, 2006) and Chinese-Australian families, (Wilton, 1994). Interviewing professionals planning on making an upward move, or at least to maintain equilibrium in terms of resources and reputation is more likely to suggest a less easily glossed over or mythologized account. Measures of success and failure are clearly in evidence and publicly available. More important, what might be identified as a 'silence' over experiences of racism (Wilton, 1994) may offer more complex interpretation if all the many different personal accounts of discrimination are added into an account. So, for example, stories of discrimination may need to be heard within the contexts of experiences of class, caste and cultural oppression in the country of origin. On arrival, threats to professional status from the undermining of skills, or the limitations of the professional labour market may be considered as similarly oppressive. Under

such circumstances, racism may be only one amongst many marginalising experiences, not silenced but contextualised.

In what follows we combine what we have drawn from the migration literatures and from our overview of oral history's approach to migration research with evidence from the interviews to consider four themes: social cognitive networks; the structural temporariness of networks; the embodiment of patronage in networks; and networking across disciplines.

Socio-cognitive networks – the medical empire

Our research suggests that social networks were clearly important for the geographical and career mobility of South Asian doctors who came to the UK. The data gathered so far indicates a range of interrelated social and occupational networks which become salient at different stages of the migrants life histories and have a range of effect. From the data analysed so far it is clear that, in line with the dominant literature, for many migrants their social networks play a key role in shaping migration.

Initially, it is important to recognise that migration may have occurred due to people's ability to activate particular connections while being unable to mobilise others. For instance, many of our interviewees were critical of networks in the UK but many argued that the UK was more meritocratic than South Asia. They felt that they could not get jobs or their scope for career development was constrained in their home countries due to inequity based on caste, religion, region or political affiliation.

At the same time, they felt drawn to the UK because of the power of narratives related to training in the UK. Doctors, in South Asia were already part of a socio-cognitive community for whom some markers of participation in the UK labour market were central to notions of career progression. Migration to the UK for the purpose of training, gaining membership of prestigious UK Royal Colleges (MRCP etc) has long been embedded in South Asian doctors' professional cultures (Raghuram, forthcoming). All the informants stated that their lecturers in medical school had undergone some form of training in the UK and that upgrading and validating ones skills through training at one of the UK royal colleges was seen as crucial to being recognised as a good doctor. Thus, the doctors' mobility was already embedded in a network of professional development which valued at least temporary movement to the UK. Moreover, at least in medicine, the power of empire continued to be forceful as medical practice and qualifications were very much influenced by regulating bodies and by professional organisations, located in the metropolis. These organisations implicitly shape migration (and indeed directly benefit financially through it) through their ability to award internationally accredited professional qualifications. Doctors were thus already in some ways part of a professional community where migration to the UK was seen as part of career progression.

However, while socio-cognitive networks functioned well for some, this was not always the case. Despite the apparent internationalism of medical knowledge, there might sometimes be a breakdown in this connectivity.

Barriers based in traditions of assumed superiority or straightforward prejudice might present substantial impediments to mobility inside the UK. The following quotation illustrates this point:

P0021 No. I always had a job. I've never ... only when I first came for the first two weeks I didn't have a job. The first two weeks I was getting acclimatised, wondering what to do then my brother found this. And I sent job applications with my reference from consultant and so on and didn't work at all, you know, when I first came. I sent lots of applications with copies of my glowing reference from my consultant in Sri Lanka, didn't help at all.

P Really. And CV, none of that helped then?

P0021 No, no. I suppose I didn't really try hard enough I think because I thought the thing is to get a job and get some money. Close to a place where I could still come to my brother's place. Yeah. So I think once you get a good reference then it's good. But patronage definitely helps because I've certainly seen British people doing it too. They know somebody who knows somebody and they are ... it's more difficult now, it's more fair actually now. Patronage doesn't help that.

It appears that letters of reference written by doctors who had trained in the UK but had returned to South Asia were not really considered adequate for a substantive post, although the structure of the medical labour market that was based on permanent dependency on a rotating pool of temporary staff did provide an entry point for doctors as we discuss below.

The structural temporariness of the labour market – leverage for personal networks

For most migrants their original social networks played a significant role in facilitating and lowering the costs of the process of migration to the UK and in securing their initial posts in the NHS. Families often played a key role in financing the move to the UK particularly those from upper class backgrounds or with a family history of migration. Those with relatives already in the UK were given material support such as funding travel and the settling in period and providing accommodation. Finding a way into the NHS might be assisted by a period of 'honorary' employment or 'attachment' which would be unpaid. For those who migrated in the 1960s, 1970s and even later, stringent currency controls meant that people with family or friends who could provide accommodation and material support for the early period in the UK were at a significant advantage. Whilst many had support from family in finding accommodation and in their early period in the UK, some also received material support from alumni usually seniors or classmates from their medical school in the form of accommodation and subsistence. However, the most salient types of support received from alumni was in the transfer of knowledge of the UK medical labour market and its regulation. Alumni often supplied knowledge of how to migrate as a medical professional and the structure of the labour market, what jobs are available and strategies for career development.

Critically they often provided access to the recruitment networks for junior doctors. They would provide information about short term employment usually either locums (covering for absent doctors) or attachments and would often vouch for the person to their colleagues to facilitate their employment. Those without access to a supportive network might find this initial period of insertion difficult and lonely. N describes his first six months, filling locum posts: what followed next:

L0025 Then I met a friend who came down one day, he used to work here in UK and so I talked to him about that, what is the opportunities for training in the UK. He said "They are not great" (laughs) "But if you are lucky probably you may start in some place, get in there" But he himself was only (inaudible) United States so he wasn't particularly helpful to me. So he helped me to contact the General Medical Council for my registration, at least I had some contact, some direction to get the registration. Once I was registered – he was still there at that time, yeah, and he said that "I could be able to arrange a locum job for you" and so that was in St Helen's Hospital in Liverpool. So he arranged a short locum for me there, for a week or two or something. Then following that I wandered around all over the UK looking for a job from Brighton to Aberdeen wherever I could find a locum. Could be one week, two week, three weeks. It was difficult. I also worked in Charing Cross in London. Psychiatry, did medicine, to whatever the subjects. Survival was important, money was important, you need a shelter, you need a food, so whatever the job comes up you take up. (laughs) So it was challenging days.

And:

P0021. You know before all these systems came it was quite common for me for example to ring my friend in Eastbourne and say "Hey look there's a Sri Lankan doctor who's very very good, he's done very nicely, he's coming over and he has a sister in Eastbourne he's staying with. Are there any jobs coming up there?" Then he will say "Well there are no jobs here but there is a locum that I'm looking for. In fact I'm stuck actually I need a locum in situ very badly. Would your chap ..." I said "Yeah, he would be very good" So he offered the locum to him. And then he got his first job you see and got a reference. And that's the first thing, you need a reference. Because if you get a reference from Sri Lanka it doesn't mean the same thing as one from here. Oh then he would say "A permanent job is coming up, you can apply but of course I can't guarantee the job you will have to come for interview and see" and obviously you can't plant but you can get opportunities like that. And locums were the greatest opportunity because you can't give a person a permanent job, you know, but you can always give a person a locum. And there was no compassion at all to even advertise for a locum. And the hospital authorities were very happy because they were saying "My God we want a locum doctor. Do you say that's a nice Sri Lankan doctor and he says he's good, we can take his word for it" and

they appointed. So we used to certainly phone each other and say if we know and that used to start from Sri Lanka.

It appears that the connections formed by doctors before they migrated could be used for leverage into accessing locum posts. But it is the structure of the medical labour market abundant availability of short term, temporary, posts provided the space that allowed these networks to be effective. It appears that they were not adequate for more permanent posts. Nevertheless, the short-term posts were, for our interviewees, crucial for access to more permanent jobs in the UK labour market as they provided the possibility for obtaining formal and informal recommendations which could be used to seek more secure jobs.

Several also mentioned that they were more likely to gain early posts if another alumni from their medical school had previously worked there as previous experience with graduates of that particular medical school validated their skills and qualifications and provided the trust and certainty automatically given to UK trained graduates. However, they were rarely able to dispense jobs to other migrants themselves; rather it was through introducing alumni to their usually white consultant that these very junior posts were filled.

Access to these very junior early posts allowed the migrant to establish the relationships with more senior colleagues such as consultants (and registrars) which would prove critical for their career progression in the UK. As we go on to discuss, these patronage based relationships are key determinants for the development of successful medical careers in the UK. On some occasions some of the migrants were made permanent in their locum posts after impressing their consultants. However appointments like this were reportedly not the norm and the most common way in which career mobility was facilitated was through more indirect and networked forms of patronage described below.

The embodiment of patronage in networks

Once in post, migrant junior doctors engaged with their consultants as patron and client (or disciple, mentor and guru) and were expected to demonstrate attributes deemed by the consultant to prove their potential as physicians. Formally, the South Asian doctors were no different to any other junior doctors, though they might of course have accumulated more experience before leaving their home countries. The attributes which were likely to lead to upward progress reportedly included hard work, clinical skills and communication skills.

L0025 In that post I spent most of the time in the ward looking after the patients. Being totally committed to the patients and teaching. And making myself known by presenting cases to the various groups of meetings. I even published a paper I think – no I wasn't published at that time, no. Whatever I could do locally to people to know me I made every effort. When most of the people might go home by five o'clock I never went home until I see my last patient. I stayed back to see that (inaudible). And so one day one of the consultants turned up at about

six thirty, seven in the evening and he saw me still doing the round and said “What are you doing there?” “I’m finishing my patients. Still there are two more left” He said “You are too dedicated” he said, and the next year recommended me for a senior registrarship post to the professor.

In return for demonstrating their competence interviewees reported a range of support given to junior doctors by consultants such as advice on career development and most importantly formal and informal references on which to build their a reputation and access to job opportunities through the professional networks inhabited by the consultant. This included notice of and preference in appointment within hospitals and also support in gaining employment outside the hospital. For the South Asian junior doctors at least, career mobility usually involved a great deal of geographical mobility through taking posts in different areas. They were therefore not known by interview panels and recommendations from consultants to others in their professional network were crucial for success in securing employment. Informants related a range of practices, some which would today contravene diversity legislation, whereby consultants would promote the interests of their juniors within their professional networks for example telephoning members of interview panels.

This served the interests of the migrant in allowing them further time to adapt to UK professional and organisational cultures, clinical practices and develop their communication skills in an environment which would enable them to study for their membership examinations. The consultants’ interests were served by employing a junior doctor of proven reliability often at a time of labour market shortage:

L0022 After working there for a month the day before the interview for the permanent job he said to me just casually, he said “I’ll see you tomorrow at the interview” and I said “I’m sorry Sir I haven’t applied, or what interview?” and he said “Haven’t you applied for the substantive job?” and I said “No. I was waiting for you to tell me that I should apply” because that had been my experience in (hospital) you see. And he said “Oh no, no, why haven’t you applied. Hold on a minute” And he rang the medical personnel and he said “Include Dr N. I’ve got his application, I’ll bring it tomorrow, include Dr N in there for the interview” and that’s how I got the Registrar job in general medicine. (laughs) So it was – had I applied simply I suspect he would have looked at either the name or the whatever criteria they applied and probably I wouldn’t have been shortlisted.

However, this very informality and dependency on a particular consultant at the heart of his (usually) network, could have negative outcomes for South Asian doctors. Barriers rooted in racist attitudes and discriminatory practice might not be obvious, but they wouldn’t go unnoticed:

L0022 Now in 74/75/76 if you applied for – there were popular jobs – if you applied for obstetrics, gynaecology being an Indian you hardly ever got it. If you did you got it and you stayed at SHO level, you didn’t get a Registrar job. And to get a Registrar job would have been extremely difficult. There were, there were instances where the Consultants said

“I have shortlisted, this is my shortlist. I have included all those that I could – the names I could pronounce and spell”

Conversely not maintaining a close relationship with their consultant could have harmful effects on career mobility. Some informants suggested that references could be withheld or written references would contain codes encouraging members of the panel to discuss the applicant over the telephone.

Consultants in their networks operated as patrons, but with all the professional and personal idiosyncrasies of the powerfully placed. For the South Asian overseas trained doctors, both junior in the hierarchy and new to the culture of the NHS, finding a way through and up could be hazardous, but perversely, geriatrics offered a way that other specialties did not.

Networking across disciplines

For all the informants Geriatrics was not their first choice of specialty rather their entry to the specialty was a result of an interplay between the failure of their connections to facilitate entry into the specialty they hoped to enter during their time in the NHS and the support given by their network in finding alternative channels of career advancement. All those interviewed reported that their networks were not able to overcome barriers to entry even in times of relative labour shortage. After repeated failure to secure a post as a consultant or specialist registrar in their chosen specialty all the informants who subsequently became consultants (14/16) were advised by their patrons that as overseas trained doctors the most direct route to becoming a consultant was to become a geriatrician. This repeated pattern of pressure on overseas doctors to enter geriatrics rather than their chosen specialty can be seen as reinforcing their marginalisation from the mainstream labour market as whilst their patrons highlighted the realities of discrimination against foreigners in the networks in which they of course played a critical part they apparently did little to challenge the discriminatory practices within their networks⁴. Those interviewed were of course aware that geriatrics had a low status:

L0023: ...the day I walked into Hammersmith and there was a locum registrar, he's a lung specialist now I think. I think, I don't know, but he's in some speciality, not in geriatrics and his thing was "Really this is the backwaters of Hammersmith you've got into. This is not the ... you should have been in cardiology, which you are not. And this is just the backwater, it's not worth it" So in fact he openly told me on the day one "You are in the backwaters" And I didn't confront him because, you know, it's a first, you know, encounter, but I thought in my mind what he means to say is that geriatrics is not the front runner. But that's not Hammersmith, that's not London, that's the world. The world is seeing geriatrics like that. And that's all he's telling me is that if you go and become a geriatrician or India or America it would be the same because even there the speciality was seen as a low priority new speciality.

However patrons could also offer advice on the basis of their analysis of gaps in the labour market and future developments within medicine. Sometimes this might be more than simply verbal:

L0026: I moved from one consultant to the other who was a rheumatologist. He was very kind. And he sat down within the first four months he said "I've seen you for the past year, you were excellent, I want you to be a consultant in this country and geriatrics, even though I'm a rheumatologist" He did partly geriatrics even though he was a rheumatologist in the community hospital. He said "I think you should become a geriatrician. The reason I am saying is the job market is open now. It will close in another ...". That's the first time I heard a sort of proper career advice, talking about job market. I'd never heard that word until then. I thought, just funnily I brushed it off. He gave me that advice and he said "Go and think about it, come back in two weeks". I didn't even think about it. I forgot that he spoke. Two weeks later he called me in to say "I said you should come and talk to me in two weeks, why have you not talked to me in two weeks?" I said "I've not made a decision" "I want you to make a decision now because time is running out. You've got six months to get into an SPR job otherwise you've no choice, because of the visa system you have to get a work permit and you can't work in a training job then, you have to become a staff grade. So you should make a decision now" And that's partly because that's the year I got married. It was about nine months into my marriage and so I was enjoying my initial married life, didn't think about anything else. But he was very insistent and I think he did the right thing for me. And he, on that day, I'll never forget, I still have it with me, gave me the reference and he said "I'm going to give you a reference for geriatrics. I want you to go and read this in private." And it was a three page reference. He said "Come and tell me what you think about the reference. If you think you can add anything more positive to that reference I will add it" And I thought that was the best personal advice I ever had,

There is more than one way of viewing this particular aspect of networking, the clustering which occurred in geriatrics was also a result of recognition of opportunity. If there was a shortage in that particular area of medicine then this was a gap that could be filled and with guaranteed positive outcomes:

L0025: I knew that I will never get a job in general medicine, it is highly competitive and the preference is given to the local population. I didn't feel bitter about it because I've experienced that before in another country. (laughs) So I didn't feel bitter about it. I said "Whatever the job I get I'll take geriatric medicine and then see how it is" Within six months I cleared the membership, part of it at least.

And:

L0023: Because my consultant, who was exactly like me, I know him now, he was a trained cardiologist and then there were openings in geriatrics so he quickly moved into that area and he said "Look if you want to go through the fast track up then this is a less crowded road.

You could do geriatrics and you could do cardiology and you could, it would be a good way up rather than waiting in the queue”

Most of those interviewed came to the UK with a particular specialty in mind, cardiology, gastro-enterology, neurology, general medicine, they were quickly disabused of their ambitions and found a new chosen career in geriatrics. This movement across disciplines brought benefits in terms of training and progression, however, the very nature of geriatrics meant that many were able to maintain a specialist interest, while some went on to specialise within geriatrics. While the broad scope of geriatrics marks it down as a non-specialty in the eyes of some doctors, for others it offers an opportunity to gain experience of a wide range of acute and longer-term conditions and to work with other professionals, social workers, occupational therapists and nurses in less hierarchised working arrangements. And for those interested in developing a research base, there is the possibility of work to develop treatment of stroke, Parkinsonism and other conditions more typical of late life. Once inside the specialty, these more successful geriatricians describe careers which have brought research-based as well as material rewards.

As stated earlier the nature, role and power of the networks has changed considerably over time. They appeared to have played a far greater role in the earlier periods of our study (i.e. between 1960 to 1990 or so) than they do more recently. For the doctors we interviewed, at least three types of changes seem to have been important. First, race regulations have altered the parameters of discrimination. The effect of ethnicity on discriminatory practices has been somewhat muted although that against international medical graduates (IMGs, as they later came to be called) appears to have strengthened and to have become enshrined in law (Mackintosh et al., 2006). Over time, the structuring of career progression and the overt markers of achievement and career progress also seem to have solidified so that discriminatory recruitment based on ethnicity is harder to justify. On the other hand, the competition for posts goes through peaks and troughs, depending on the size of the UK medical graduate cohort as well as that of IMGs, in relation to the controlled size of the medical labour market. The role of networks too altered with these changes. Over time, the status of geriatrics as a discipline and its desirability for non-migrant doctors also changed as did the shortage of doctors in other specialties such as psychiatry, paediatrics and orthopaedics so that the kinds of areas into which migrants moved and the nature of how networks shaped the discipline also altered. At the same time that geriatrics became more competitive, other specialties became less so, although even today geriatrics retains a strongly clustered South Asian workforce.

Conclusion

The literature suggests that migrants tend to be channelled and contained almost exclusively within migrant networks and clusters. However, the oral history data suggests a more complex reality, with migrant doctors playing a more active role in populating and devising networks, acknowledging power

relationships within networks and generally indicating a tension between the informalities operating in medical hierarchies and the formal pressures generated by recruitment and professional development. It appears through migration that some links can be made to count at some points while others become redundant. Disconnections, connections and reconnections all feature in the story of how migrants relate to family, alumni and patronage networks. Networks do not provide an infrastructure for migrants but rather are activated differentially at different points in the process of geographical and career mobility. Moreover, the role and nature of networks in these processes change for both migrants and non-migrants over time.

In tracing these connections we identified four themes drawn from our analysis of the interviews so far transcribed for our project: The importance of social cognitive networks in shaping migration; the role of structural temporariness within labour markets in allowing migrants to utilise their pre-migration social networks to first gain access to the labour market; the embodiment of networks in distinct individuals who became brokers facilitating further career development; and the networking across disciplines that channelled migrant doctors into geriatrics. Each suggests that a more ambivalent approach to ideas of social networking and clustering may be more fruitful. Introducing a sense of temporality, leads us to suggest the need for a more fluid understanding of networks than the literature suggests. Time over an individual's life, time in the development of a specialty such as geriatric medicine and changes in recruitment policies of overseas trained doctors all shape and determine the flexibility and powers of social networks.

As important, perhaps is awareness of these doctors' own agency in the management of the uncertainties that these networks presented to them. Where some expectations were to be fulfilled, for example in relation to the role of family and friendship support networks, others were to be dashed. What seems to be emerging from our data is that migrant networks must be recognized as just one form of network that migrants belong to and that in managing and coping with these networks, medical careers were built, some more some less successfully and the geriatric specialty was made and continues to be made through these networks. As we continue with our project, we hope to shed more light on the contribution of South Asian overseas-trained doctors to the development of a specialty, and more specifically to the medical care of the oldest generations in the UK.

References

- Anderson, W D (2001) 'Oral history and migrant wage labor: sources of narrative distortion', *Oral History Review*, 28, 2, pp 1-20.
- Anthias, F. (2007) Ethnic ties, social capital and the question of mobilisability, *The Sociological Review*, 55 (4), 788-805.
- Anwar, M. and Ali, A. (1987) *Overseas Doctors: Experience and expectations. A Research Study*, London, Commission for Racial Equality.

Bauer, E & Thompson, P (2006) *Jamaican hands across the Atlantic*, Kingston, Ian Randle Publications.

Beaverstock, J. (1994) Rethinking Skilled International Labor Migration: World Cities and Banking Organizations, *Geoforum*, 25:323-338.

Beaverstock, J. (1996) Lending Jobs to Global Cities: Skilled International Labor Migration, Investment Banking and the City of London, *Urban Studies*, 33:1377-1394.

Beaverstock, J. V. (2002) Transnational elites in global cities: British expatriates in Singapore's financial district. *Geoforum*, 33, 4, 525-538.

Bertaux-Wiame, I (1979) 'The life history approach to the study of internal migration', *Oral History*, 7, 1, pp 26-32.

Bornat, J (2004) 'Chance as narrative theme or pragmatic function? Geriatricians recall their careers'. Paper presented at the Fifth European Social Science History Conference, 24-27 March, Berlin

Bonacich, E. (1973) A theory of middleman minorities, *American Sociological Review*, 38(5): 583-94.

Bourdieu, P. (1986) 'The Forms of Capital' in Richardson, J. (ed.), *Handbook of Theory and Research for the Sociology of Education*, New York: Greenwood Press: 241-258.

Boyd, M. (1989) 'Family and personal networks in international migration: Recent developments and new agendas,' *International Migration Review* 23(3): 638-70

Campani, G. (1994) Ethnic Networks and Associations, Italian Mobilization and Immigration Issues in Italy of Rex, J., Drury, B. (eds.) *Ethnic Mobilisation in a Multicultural Europe*. Aldershot: Avebury: 143-48

Coker, N. (ed.) (2001) *Racism in Medicine An agenda for change*, London, King's Fund Publishing.

Chamberlain, M (1994) 'Family and Identity: Barbadian migrants to Britain' in R. Benmayor & A Skotnes, (eds) *Migration and Identity*, Oxford, Oxford University Press, pp 119-135.

Chamberlain, M & Leydesdorff, S, (2004) 'Transnational families: memories and narratives', *Global Networks*, 4, 3, pp 227-241.

Colic-Peisker, Val (2006) Employment Niches for Recent Refugees: Segmented Labour Market in Twenty-first Century Australia, *Journal of Refugee Studies* 19(2):203-229;

- Decker, K. (2001) 'Overseas doctors: past and present', in N. Coker (ed) *Racism in Medicine: an Agenda for Change*, London, King's Fund: 25-47.
- Dicken, P., et al., (2001): Chains and networks, territories and scales: towards a relational framework for analysing the global economy. *Global Networks* 12:89-112
- Esmail, A. and Carnall, D. (1997) 'Tackling racism in the NHS', *British Medical Journal*, 214: 618.
- Essed, P. (1991) *Understanding Everyday Racism*. Newbury Park, California: Sage.
- Evans, J. (1997) Geriatric medicine: a brief history, *British Medical Journal*, 315, 1075-1077.
- Girard, E.R. and Bauder, H. (2007) Assimilation and Exclusion of Foreign Trained Engineers in Canada: Inside a Professional Regulatory Organization. *Antipode* 39: 35-53.
- Goldacre, M. Davidson, J. and Lambert, T. (2004) Country of qualification, ethnic origin of UK doctors: database and survey results, *British Medical Journal*, 329, 597.
- Greve, A. and Salaff, J. (2005) Social network approach to understand the ethnic economy: A theoretical discourse, *Geojournal*, 64: 7-16
- Findlay, A.M. (1990) 'A migration channels approach to the study of high level manpower movements: A theoretical perspective' *International Migration* 28: 15-23
- Halfacre, K H & Boyle, PJ, (1993) 'The challenge facing migration research: the case for a biographical approach, *Progress in Human Geography*, 17, 3, pp 333-348.
- Henry, L. and Mohan, G. (2003) Making homes: the Ghanaian diaspora, institutions and development, *Journal of International Development*, 15, 5, 611-622.
- Ho C. (2006) Migration as feminisation: Chinese women's experience of work and family in Australia. *Journal of Ethnic and Migration Studies* 32: 497-514.
- Hondagneu-Sotelo, P (1994): *Gendered Transitions: Mexican Experiences of Immigration*. Berkeley: University of California Press.
- Hüwelmeier, G. (2001) Women's Congregations as Transnational Communities. *WPTC-2K-13*.
- Jefferys, M. (2000) 'Recollections of the pioneers of the geriatric medicine specialty', in J. Bornat, R. Perks, J. Walmsley and P. Thompson (eds) *Oral History, Health and Welfare*, London, Routledge: 75-97
- Kloosterman, R. and Rath, J. (2001) 'Immigrant entrepreneurship in advanced economies: mixed embeddedness further explored', *Journal of Ethnic and Migration Studies*, 27(2): 189_202.

- Kyriakides, C. and Virdee, S. (2003) Migrant labour, racism and the British National Health Service, *Ethnicity and Health*, 8, 4, 283-305.
- Mackintosh, M. Raghuram, P. and Henry, L.W. (2006) A perverse subsidy: African trained nurses and doctors in the NHS, *Soundings*, 34, 103-113.
- Massey, D. et al. (1993) Theories of international migration: a review and appraisal. *Population and Development Review* 19/3: 431-466.
- Meyer, J-B. (2001) 'Network approach versus brain drain: Lessons from the diaspora,' *International Migration* 39: 91-108
- Nagel, C. (2004) "Skilled migration in global cities from 'other' perspectives: British, Arab, identity politics and local embeddedness", *Geoforum*, 36, 2, 971-987
- Ong, A. (1999) *Flexible Citizenship*. London: Duke University Press.
- Poros, M. (2001) 'The role of migrant networks in linking local labor markets: The case of Asian Indian migration to New York and London,' *Global Networks* 1(3): 243-59
- Portes, A. (ed.) (1995) *The Economic Sociology of Immigration. Essays on Networks, Ethnicity and Entrepreneurship*. New York: Russell Sage Foundation.
- Raghuram, P. (forthcoming) Caring about the brain drain in a postcolonial world, *Geoforum*.
- Raghuram, P. and Kofman, E. (2002) The State, labour markets and immigration: the case of skilled emigrants in UK's medical labour market, *Environment and Planning A*, 34, 11, 2071-2089.
- Raghuram, P. (1999) 'Interlinking trajectories: migration and career paths among domestic workers in Delhi, India', in Momsen, J. (ed.) *Gender, Migration and Domestic Service*, Routledge: London.
- Reid, W. and Rubin, R. (2003) Integrating economic dualism and labour market segmentation: the effects of race, gender and structural location on earnings, 1974-2000. *Sociological Quarterly*, 44, 3, 405-432.
- Robinson, V. and Carey, M. (2000) Peopling skilled international migration: Indian doctors in the U.K.. *International Migration*, 38, 89-108.
- Salaff J, Greve A. (2003) Gendered structured barriers to job attainment for skilled Chinese emigrants in Canada. *International Journal of Population Geography* 9: 443-456.
- Schrover M, van der Leun J, Quispel C. (2007) Niches, Labour Market Segregation, Ethnicity and Gender. *Journal of Ethnic and Migration Studies* 33 4: 529-540.

Slade, B. (2003) Gender, Race and the Social Construction of Skill in Canadian Engineering: The Deskilling of Immigrant Women Engineers. Canadian Association for the Study of Adult Education. Available at: http://www.oise.utoronto.ca/CASAE/cnf2003/2003_papers/bonniesladeCAS03.pdf (accessed 10 June, 2007)

Shah, N.M. and I. Menon (1999) 'Chain migration through the social network: Experience of labour migrants in Kuwait,' *International Migration* 37: 361-80

Shih J. (2006) Circumventing Discrimination: Gender and Ethnic Strategies in Silicon Valley. *Gender and Society* 20: 177-206.

Smith, D J (1980) *Overseas doctors in the National Health Service*, London, Policy Studies Institute.

Smith, G & Nicolson, M (2007) 'Re-expressing the division of British medicine under the NHS: The importance of locality in general practitioners' oral histories', *Social Science & Medicine*, 64, pp 938-948.

Thane, P. (2000) *Old Age in English History: Past experiences, Present Issues*, Oxford, Oxford University Press.

Thomas & Znaniecki (1927) *The Polish Peasant in Europe and America (1918-1921)*, New York, Knopf

Thompson, P (2000) *The Voice of the Past*, Oxford, Oxford University Press. Third edition.

Thomson, A (1999) 'Moving Stories: oral history and migration studies', *Oral History*, 27, 1, pp 24-37

Vertovec S. (2002) Transnational networks and skilled labour migration, WTPC-02-02, available at <http://www.transcomm.ox.ac.uk/working%20papers/WPTC-02-02%20Vertovec.pdf>

Waldinger, R. (1994) 'The making of an immigration niche', *International Migration Review*, 28(1): 3_30.

Wilton, J. (1994) 'Identity, racism and multiculturalism: Chinese-Australian responses' in R. Benmayor & A Skotnes, (eds) *Migration and Identity*, Oxford, Oxford University Press, pp 85-100.

Xiang, B. (2001) 'Structuration of Indian information technology professionals' migration to Australia: An ethnographic study,' *International Migration* 39: 73-88

TABLE 1. *Junior hospital medical staff by speciality and country of birth, 1975, England and Wales(a)*

Speciality	All birth places	Percentage born outside the British Isles	
General medicine	2,601	28.6	
Diseases of the chest	222	61.7	
Cardiology	139	28.1	
Geriatrics	646	83.6	
Ophthalmology	317	81.4	
Neurology	150	32.7	
Paediatrics	886	35.3	
General surgery	2,313	41.6	
Ear, nose and throat	381	80.8	
Trauma/orthopaedic surgery	898	72.9	
Accident & emergency	968	60.3	
Thoracic surgery	147	66.7	
Neuro surgery	115	67.8	
Anaesthetics	1,439	62.7	
Radiotherapy	137	49.6	
Radiology	161	40.4	
Gynaecology obstetrics	1,593	61.6	
General pathology	287	53.3	
Mental illness	1,110	63.7	
All specialities (b)	15,380	52.2	

a Only includes Registrar, Senior House Officer, and pre and post-Registration House Officer grades.

b Specialities with fewer than 100 junior medical staff are not shown separately but are included in the total.

Source: DHSS Statistics and Research Division (cited in C. KYRIAKIDES AND S. VIRDEE (2003) 293, table 4).

TABLE 2. *Hospital medical staff by grade and country of birth, 1975, England and Wales*

Grade	All birth places	Born outside the British
	Isles	
	<i>N</i>	<i>%</i>
Consultant	11,482	14.2
SHMO with allowance	17	11.7
SHMO without allowance	190	14.2
Medical Assistant	1,072	35.1
Senior Registrar	2,317	27.7
Registrar	5,121	57.4
Senior House Officer	7,709	60.0
House Officer post-registration	315	41.2
House Officer pre-registration	2,235	15.1
Other staff	45	35.5
All staff	30,503	35.2

Source: DHSS Statistics and Research Division (cited in C. KYRIAKIDES AND S. VIRDEE (2003): 292, table 3).

¹ In this paper we use the term overseas doctors for most of the paper, in line with the early use of this term to cover medical migrants. More recently they have come to be called International Medical Graduates or IMGs.

² ‘Overseas-trained South Asian doctors and the development of geriatric medicine’, ESRC grant reference number: RES-062-23-0514.

³ Examples from the UK include: ‘*How far do leaves fall?*’ DVD, Chinese Mental Health Group, www.cmha.org.uk; *Belonging: Voices of London’s Refugees*. Exhibition at the Museum of London, 2007, *Memories of from Emilia Romagna and Sicily*, exhibition 2006, Ann Kramer, *Many Rivers to Cross: the history of the Caribbean contribution to the NHS*, 2007; projects in progress in 2006-8 include, *Moroccan Memories*, Swadhinata Trust’s oral history of the Bengali community in East London, Huddersfield Ethnic Voices Oral History Project (for more information on these and other projects consult back issues of *Oral History*).

⁴ Our methodological focus on geriatricians in the UK has meant that we do not know how people managed their networks in order to obtain jobs in other sought-after specialties such as surgery. Nor do we know about doctors for whom networks failed so that they had to return to South Asia, or about networks that facilitated movement to other countries.