'Don't mix race with the specialty' (retired South Asian consultant geriatrician): interviewing South Asian overseas-trained geriatricians

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Abstract

Several of the pioneers, interviewed by Professor Margot Jefferys in 1990-1, who developed geriatric medicine during the mid twentieth century make passing reference to the South Asian doctors who played a significant role in building the specialty. However, amongst over 50 geriatricians she interviewed, only one was from South Asia. A new project, funded by the ESRC, aims to make good this deficit by recording the experiences of South Asian geriatricians in the organisational and scientific development of the provision of medical care for some of perhaps the most marginalised groups of NHS patients, frail older people. The paper draws on these interviews to consider how opportunity, status and career are negotiated in oral history interviews in relation to such factors as racism and discrimination, particularly given the need to record personal achievement and professional reputation within what is a strongly hierarchised area of employment. It explores the constitutive role of this part of a global workforce in building up a National Health Service.

The intersection of two seemingly marginalised groups, frail older people and South Asian overseas-trained doctors, provides an opportunity to investigate the development of a medical specialty and migrant roles within the twentieth century UK National Health Service (NHS). Geriatric medicine grew from only a handful of consultants willing to identify themselves with a disregarded area of healthcare in the first few years of the NHS to become a specialty, with a membership organisation of just under 900 hospital consultants, the second largest medical specialty by the first years of the twenty-first century[1]. In part responding to the dire medical neglect of older people within the NHS hospital system and in part to government and management pressure to improve bed occupancy figures [2], geriatric medicine grew rapidly, to a large extent depending on recruits from overseas for its expansion. A new project, funded by the Economic and Social Research Council [3], is currently interviewing 60 doctors from South Asia who worked or still

work in geriatric medicine in the UK. Our aim is to investigate South-Asian overseas trained doctors' responses to recruitment into a highly differentiated environment and assess their contribution to the emergence of the specialty of geriatric medicine. In this paper we focus on how the experience of that intersection is reported in the interviews. In particular we consider whether the dissociation of race and the specialty constitutes a silencing of the experience of racism and with a view to contributing to discussions of how post-colonial elite migration is positioned in the literature.

Race and the specialty

Previous research has shown how South Asian overseas trained doctors are ethnically marked both through race and also through their countries of qualification[4]. In such a context, how do the doctors in our sample recall their experience of difference and discrimination and what can we learn from their recall? Migrant doctors, since the inception of the National Health Service, have been seen as an integral but devalued part of the health workforce. Researchers have drawn on colonial language with words such as 'sepoy' and 'indentured labour' pinpointing the situations of trained migrant doctors and the organization employing them [5]. These doctors 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 [6]. The fact that in 2003, only 17 per cent of South-Asian doctors were consultants compared with 42 per cent of white doctors [7] provides some evidence that migrant doctors from South-Asia continued into the present century to find their careers limited by the institutionally racist and hierarchical nature of the NHS [8]. Since its inception, geriatric medicine had been a 'Cinderella specialty' [9] occupied as it was with one of the least regarded groups of patients [10]. As such,

and by way of contrast, it came to be a field where South Asians could find 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 [11].

The employment of South Asian overseas trained doctors in geriatric medicine offers an interesting case study with which to consider the intersection and interactions between migration, status and discrimination, in relation to both doctors and their patients. An oral history approach, interviewing doctors about their lives and careers brings the daily and lived experience of these issues into closer focus. The exhortation not to 'mix race with the specialty' highlights the dilemmas faced by those doctors as they recall their careers and by us the researchers as we consider the accounts we are eliciting. To discuss the impact of racially-based discrimination on the lives of the South Asian doctors and their families involves hearing about experiences of racism in the NHS and UK but set alongside records of personal achievement and realized ambition. How then to weigh up these accounts? In their own words, these doctors are not victims yet, also in their own words, only one would have chosen to work in geriatric medicine on first arriving in the UK. They are successful migrants who have become committed to a career in an unpopular specialty, as one interviewee, now a leading hospital consultant, pointed out:

> *… for instance I went to a membership* [12] *course here and I went to meet the consultant who was running the membership course. I had to do the part two membership and I needed to be on a course. And he just asked me 'Where are you working?' and I said 'In geriatric medicine'. 'I'm sorry, we don't allow people in geriatric medicine to come on this course'. So I was excluded from the course…So it wasn't very popular, geriatric medicine wasn't very popular. Geriatricians weren't very popular. They were second class citizens.* [13]

In keeping with its own radical and political development, oral history's exploration of migrant history has focused 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. However, by not paying attention to skilled migrants we may miss out on hearing how stories of success are narrated, how opportunities are determined and how more subtle adversities are dealt with, thus deepening understandings of the interplay of migration, race and hierarchies of power. Skilled migrants may experience deskilling and may become underprivileged. Focusing on those who are less advantaged may lead to the assumption that skilled migrants only narrate stories of success and do not face these problems.

In a review of oral history's contribution to migration studies over the previous twenty five years Al Thomson argues a role for oral history in revealing a 'hidden history of migration' [14] 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 how 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. 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 oral history literature, however, is a perspective which is inclusive of the skilled migrant. Although his own study of 'Ten Pound Poms' shows that those who migrated to Australia via the assisted passage scheme in the 1950s and 1960s were 'above the British average' in terms of skill and income levels, most typically men were skilled working and lower middle class .

These were the groups that the Australian government was seeking to help found the bedrock of post World War Two reconstruction [15]

In oral history migration studies, finding work, central to most migrant stories, is almost always linked to family and social networks of support and contact. However, family and community may play a different role in the lives of skilled migrants. To become skilled or to have the ambition to migrate may itself be a familial disposition, or may be fostered within a family. Their own way of living out their class status puts them in networks of aspirations and belonging that have already led to what Pandurang [16]calls the pre-migration experience.

Family may provide the initial starting point when cash and accommodation are needed, family and community are less likely to function as a lever into professional development. In the case of South Asian overseas-trained doctors the structures within which they work, the National Health Service and organisations of the medical profession working within it, were internationally recognised and formally delineated. However, movement within those formal structures is also determined by informalities which operate both as opportunity and constraint. Informal networks accessed through patronage and sponsorship may ease progress but they may also impede and obstruct by means of subtle and indirect excluding behaviours [17]. The historical influence of empire in a post-colonial context, and assumptions which operate through racist and other discriminatory practices may work against the interests and aspirations of these doctors. By drawing on personal experience an oral history approach enables an exploration of the ways in which the formal and publicly visible characteristics of the NHS as well as less formal workings were engaged with, as this particular group of doctors sought their way in, and upwards.

The interviewees

An earlier project, carried out in 1990-91 by the late Professor Margot Jefferys, involved interviews with over 50 of the pioneers of geriatric

medicine in the UK. Amongst these was only one South Asian geriatrician [18]. The current project aims to fill that gap by interviewing 60 retired and serving South Asian doctors (from countries including India, Pakistan, Bangladesh, Sri Lanka, Nepal and Burma). The Jefferys' interviews are lodged at the British Library Sound Archive. It is planned that the South Asian doctors' interviews, recorded and transcribed, will join the earlier collection, the two together providing an in-depth perspective of the health care of older people in the twentieth century.

Of the target sample of 60 interviews, twenty five, averaging two hours each in length have so far been completed. Of these, fifteen have been transcribed. This paper draw on those transcribed interviews, a group which includes doctors trained in India, Bangladesh, Sri Lanka**,** Pakistan and Burma, ranging in age between 40 and 81 arriving in the UK from the early 1950s onwards. 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 hospital consultants, some also holding academic posts such as that of Senior Lecturer or Professor.

The interviewees are being recruited through networks of overseas doctors (British Association of Physicians of Indian Origin for example), the British Geriatrics Society (the professional association of geriatricians) 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 and family life 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. The interview schedule also includes questions which invite reflection on their time in the UK including their experience of racism and their views of work in the geriatric specialty.

In what follows we discuss the extent to which, in these first interviews, responses to the questions we are interested in exploring are openly articulated. We do this by considering how these doctors describe and account for difference; how racism is dealt with as a topic in the interviews; and, finally, what is left out if race and the specialty are not mixed.

Dealing with difference

In beginning to analyse the interviews of these (so far all male) doctors we quickly became aware of the many ways in which they were discussing, or recounting experiences of difference, in their early lives and during their careers. Arrival in the UK meant absorbing and dealing with discriminatory practices which were not new to them, even if, in the context of their home country, these were a by-product of privilege. As in the UK, class and ethnicity were markers that many were already familiar with. And some of them had strongly questioned and rebelled against these. Many had a democratic imperative and so for many doctors the NHS with its equal access to all provided a route for living out the dream of progress and equality. A Sri Lankan doctor recalls:

> *…I hated the differences that I saw, you know. I couldn't see why servants at home had to be spoken to in different language. Why they had to sit on a lower chair or why they had to eat separately in the kitchen. Why can't they join us? And I used to hate that. Why, they are obviously human beings, why are they being treated separately? Why should the servant boy who is my age not go to school? He is at home doing menial jobs, I'm going to school. Why don't they?* [19].

Privilege might also work against opportunity under the impact of government-fostered affirmative action which muted the gains of privilege [20], as this son of an 'agricultural graduate' farmer recalls:

> *… I didn't think I was going to get into medicine because medicine was quite difficult to get into. The system in India at that time was*

there were all sorts of reservations for entry into medicine and people with backward backgrounds and people of poor background and so on were given higher preferences and so the merit only featured in about thirty to forty per cent of seats that were available. So, and I had to fight for a place amongst the merit places because we were neither financial nor educationally or politically backward. And so I didn't think I was going to get in but chemistry I scored ninety six per cent and biology also I scored something like ninety four per cent so those two carried me through. [21]

and, another, whose father was a teacher explained how:

> *…there is a reservation policy in India and unfortunately even though we are not economically forward we were called the forward caste because of caste based admissions. And only about seven per cent of the people or ten per cent of the people who were born in the forward caste would get into the elite professional courses because of the way the system is devised. So I think I was very fortunate to get into medicine, even with that reservation, being a forward caste person* [22]

Arriving in England meant getting used to other kinds of difference, some more, some less discriminatory. Being recognisably different, learning how to dress in ways that were appropriate for both climate and work situations, finding food that was customary, learning how to fend for oneself outside a family situation are all described in the accounts as if normal to acquiring migrant identity. However, their placing in narratives varies. For some, the recounting of the process of identity acquisition are described as part of the learning process of being and becoming a doctor in the UK, for others they are recalled as markers of difficulty and discrimination in transition periods when income and employment were uncertain.

These doctors, from their own accounts, felt drawn to the UK, rather than the USA, because in South Asia they were already part of a socio-

cognitive community for whom 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 [23] . All the informants stated that their lecturers in medical school had undergone some form of training in the UK and that upgrading and validating skills through training at one of the UK 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 cyclical movement between the UK and South Asia. 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. Doctors were thus already in some ways part of a professional community where migration to the UK was seen as part of career progression.

Even so, to work as a doctor in the UK meant recognizing differences within that medical network that most say they had not expected. Prime amongst these was the realization that, if they had aspirations towards certain specialties, they would be unlikely to achieve these. P022 had worked in paediatrics in India before coming to the UK in the 1960s with the intention of getting his membership in the Royal College of Physicians and hoped to continue but:

> *…when I was in Plymouth doing the first geriatric job I spoke to my consultant and told him that this was my background and he said 'Well there may be a job in paediatrics coming up locally' you know in Plymouth itself. So he introduced me to the paediatrician over there and his point blank answer was that 'Well these jobs are usually meant for Bristol graduates' you know. 'Because we are getting graduates from Bristol who are mostly Bristol medical schools, who will need this paediatrics training to go into either*

general practice or … so I don't think we can offer you this'. You know, I mean, so that was the straightforward answer. [24]

It is also true of course that UK graduates from other areas would also have been discriminated against, such was the sense of deep localism that meant that 'your boys' would be employed. Migrant doctors also strove to be considered local.

All my training was in Liverpool because, I suppose what happens is if you've got an opportunity to move up the ladder and it's local you tend to not want to move. Cos why would I move when I've got a job here which looks pretty good. So I did a three year rotational job as registrar in Liverpool in different hospitals during which I got my postgraduate degree and got a variety of training in different hospitals and different aspects of medicine. So that was very good. [25]

There was too, the effect of hierarchy, an added complexity, with Oxbridge and London candidates unseating them all.

And so applying for general medicine in those days, applying for cardiology or applying for neurology … neurology may have been difficult even for the British graduates. People used to say 'Do you have a double-barrelled name? Otherwise don't bother applying for neurology' That sort of thing. [26]

In sum, local hierarchies had a commitment to employing people who studied in the region and overseas doctors had to fit themselves into what was already an uneven mosaic of opportunity.

There were differences which led to a repositioning of the role of doctor in a health-care context where, in contrast to their previous experience, they found that team-working with other professionals was highly valued:

And … the teamwork. There was meaningful teamwork here which wasn't there. (laughs) You just go do your own work and go home.

So that made a lot of sense then. And particularly the value of team members, non doctors, paramedics, which is unknown in that part of the world. Probably they are not respected, their work is not appreciated. While here everybody's voice is heard, whether it is a physiotherapist or a nurse or anybody, which wasn't there. So early days it was a bit of a barrier there. Should I behave the way I've been used to behave or should I behave like this? And so it took me a few days to change. The main reason being is not being known how to behave with people and language being different, expressions being different. Some people started feeling that I'm hostile towards them though I'm trying to fit in (laughs). But I suppose the intonations, which was rather difficult, so probably I did make some enemies as well in the process (laughs) without knowing. [27]

As a migrant, becoming a doctor in the NHS meant recasting self identity and the learned identity of the profession of doctor within a differently ordered system of working.

Almost all those interviewed so far are presenting their life stories in terms of successful achievement of ambition through hard work and sacrifice. In these stories, geriatrics changes, from being a default career move, to an opportunity for professional development and qualification, and finally, to a space in which to manage resources, innovate services and carry out research. In this respect these doctors are no different to the Margot Jefferys' pioneers. The quotation below matches closely the experiences of several of the doctors in our sample:

So you had a struggle in the late 1950s and 1960s of chaps to get jobs - even fellows well qualified. I used to say to them, look, if for example you've trained as a neurologist or a cardiologist, your chance of getting promotion to a consultant is virtually nil and you've got to recognise that. Therefore climb down the ladder from that ambition and take up one of these others [28].

However, in the case of the South Asian doctors geriatrics, we would suggest, takes on salience as the source and cause of continuing difference and discrimination. So, for example, P022 the thwarted paediatrician quoted earlier, in accounting for his experience, sees his exclusion from paediatrics as an example of racism, 'yes there was some racism there', but also the result of prejudice towards geriatrics. As he puts it: 'their own medical graduates were finding it…quite easy to get into the mainstream jobs so there were not enough local medical graduates left to fill up these specialties' [29].

Another describes how attitudes towards geriatric medicine even affected his social interactions with colleagues:

> *Again I was supposed to look after the acute, rehabilitation, continuing care and five hospitals, running around seeing all these patients. During the hospital the prejudice against geriatric hospital is well entrenched here. Geriatricians are not considered as real consultants, or doctors even. You try to go and sit in the consultants' dining room, you get ignored, (laughs)?*
>
> *…I am talking in 1986. You get completely ignored. You don't know how to … partly I think it's a complex reasons for that, one you are new. The other consultants they knew each other, they have been working here for a long time. Second you are an Asian, ok. And you haven't got a lot of common subjects to talk to at that time. You knew very little of people. Even though you are a consultant sitting in the room. You don't know the politics of the hospital (laughs) So there was many issues were there .* [30]

Spoken in these terms, racism as an issue becomes subsumed into the identity of geriatrician and working in geriatrics.

Racism as a topic

Awareness and experience of difference is, as we've suggested a recurrent theme in the life stories of the doctors we've been interviewing. However, with the clear exception of recruitment into career grade posts

the occasions where this is translated and presented and spoken of as racism are not so common. Interviewees were asked about their experience of racism in the workplace or local community, sometimes directly, with questions such as: '…have you ever encountered anything that you'd say is like hostility towards you because you're South Asian?' or '…what's been your experience of patients' and carers' reactions to being treated by a South Asian doctor?' and sometimes by asking for elaboration or reflection, as for example, 'What do you think was going on there?' and 'And you said there were one or two incidents. How did the hospital, or your colleagues respond...?'.

Interviewees very occasionally gave examples of actions by colleagues, patients, relatives and members of the wider community but tended to distance themselves by mentioning changes in attitude over time, affecting attitudes generally as well as the advent of management policies less tolerant of racism. As one doctor put it, '…there wasn't really a big fuss about it or in those days people will not really make a big issue out of it'[31]. He had contrasted an early experience where a patient refused him as a doctor and a nurse's response being to offer an alternative doctor, with, more recently, support personally given from a Chief Executive when a relative was issuing threats.

Though episodes with patients or members of the public are recalled as painful, they tend to be dismissed as inevitable and expected:

> *…early years I had one or two bad experience where people rejected, people doesn't want them to be treated by me. I used to feel that … is that because of my colour, is that the way I'm looking? But when you are really look in depth it's only hindsight I can say that. One I didn't understand their culture. Second I wasn't understanding what they're saying. Thirdly they weren't understanding what I am saying. These things are important fact in life. They must have all contributed to this problem. And thirdly I was a training doctor, I wasn't even a full fledged doctor to stand*

firmly and confidently and to talk to the patients. So there were traumatic days. [32] .

Others explained behaviours they encountered as resulting from curiosity:

> *…many people when I go round because I've got this red mark ask me what's that red mark. When I came to this country initially I thought it was racial, but now I know it's just curiosity because it's something different they never seen. I've never found any racial element from patients. Sometimes it has happened when a very drunk patient in an A&E or something, that you would expect anywhere you worked because you always going to get it, that's never going to go away.* [33]

It is of course possible that interviewees who have been invited to talk about their contribution to geriatrics may choose to tell a positive story. Their interest lies in speaking what they present as truth. Patients' expressions, recalled as both negative and sometimes highly positive, are represented as overt and direct, by contrast, the behaviour of colleagues, including senior staff, tends to be deduced from words and deeds which were less direct, not always openly delivered. This was especially the case in relation to interviews for jobs where the informalities of patronage-based practices could have directly harmful results:

> *…the Catch 22 thing, I applied for a job, I was interviewed, in Midlands, West Midlands, in the interview room and thing and then the feedback I had was I could see my (loud noises from microphone) Mine was fifteen twenty minutes. I could see. Anyway, the feedback I had was 'Well we thought you haven't got enough geriatric experience. You need at least one year more or something, two years'. So I said 'Fine'. I think it was a couple of weeks later or a few weeks later I was interviewed in the same room for a senior registrar job. I think there were four. I didn't get the job. This time I was interviewed more like consultant interview.*

I was really grilled and I thought I had done very well. And then the feedback I had was it was the same person who said to me, 'Oh I tell you what we said about you, we thought you were too good, you were too experienced. You ought to be consultant'. It was the same person. [34].

He recalls being 'speechless' and 'I thought it was pure racist…there was no other reason'.

Looking back, it seems as if for this group of doctors the racism of patients and relatives was and possibly still is perceived and subsumed, though not condoned, as an everyday part of life in the UK. By contrast, the behaviour of colleagues and senior staff, though less openly racist, is judged more keenly. These behaviours are, of course, much more personally focused and determining, coming as they do from class equals even class superiors sometimes and have a greater impact on them. They are less easy to distance as generalised prejudice or ignorance, or to subsume under some broader category. They play a part in the narrating of career development and opportunity, as examples of obstacles overcome, as turning points and as lessons learned.

So much for the 'truths' [35] of the interview data, but what of the interviews themselves? Is the subsuming of the experience of racism a form of silencing and what do we mean by silence in these interviews? To what extent was the recording shaped by the interview relationship and by the intent of the interviewees?

Silenced or subsumed?

Ever since Luisa Passerini's critical evaluation of the silences she observed in Italian workers' accounts of life and work during Fascism the question of how to explain the absence of expected content, of '"Inconsistent" answers' as she puts it, has been troubling oral historians [36]. Passerini's first explanation was to call for a revision of ideas about anti-fascism and to suggest that the problem had been wrongly described. Anti-fascism had been defined too narrowly as political action she

argued, and needed to be redefined in order to include the culture of 'everyday life' [37] in order to develop awareness of resistance and compliance and to:

> *…perceive in what way, at the level of day-to-day subjectivity, forms of consensus and acceptance contained within themselves a potential* dissent *(her emphasis) even greater than that displayed in the more narrowly conceived political sense'* [38]

Later she was to refine these ideas. Drawing on a wide range of sources to identify different forms of silence she draws attention to the silence of suppressed memories, contrasting Jewish and Roma remembering and forgetting of the mass killings of the Nazi period as 'monumental remembrance' and 'defiant silence' respectively [39]. The silence of 'the repression of memory' and 'imposed "amnesia"' she finds in relations of oppression with examples from the Algerian and Korean wars of the early 1950s and in British representations of Irish history. Finally she suggests that silence may at times have a positive role, as in post Franco Spain, when, to avoid reliving the deep divisions of the past a form of democratically 'imposed oblivion' [40] was preferred initially.

Passerini's deconstruction of silence, looking more critically at approaches to questions asked about the past, is a helpful corrective to studies which read silence into responses which prove not to be as full as a researcher had expected. Her inclusion of the subjectivity of the interviewee, and of agency and collusion is a helpful corrective to interpretations which lean towards interviewee false consciousness in contrast with the all-knowing researcher.

Explaining the unspoken or understated in interviews tends to be associated with inequality, victimhood and historical and individual repression. Indeed it almost seems to be anticipated as a given, its identification an expression of disappointment that a story of suffering is not told in all the 'thrill' of its detail [41]. Some interviews, however, do

not fit into the traditional conventions of oral history practice. Relationships with an interviewee may be complicated by ideology and conflicted values, or as in the case of the South Asian doctors, individual histories may include the intersection of differences which complicate ideas of hierarchy and power.

From her interviews with Basque women who had experienced the violence of terrorism, as perpetrators and as victims of torture, Carrie Hamilton considers oral history's commitment to empathy in the interview, concluding that this is possible, if not confused with solidarity [42]. On one occasion, when attempting to interview the partner of a Basque separatist killed in a para-military exchange, she found herself up against what felt like a refusal to disclose. She explains this in two ways: as personal and political resistance and as a way to keep a partner's death private, away from public martyrdom. Her analysis is a reminder of agency in relation to how certain topics are spoken of in interviews.

The doctors interviewed in the main occupy positions of power, and some authority in the health system. At the same time they describe experiences of discrimination, on the basis of race and ethnicity, and in relation to the specialty in which they work. We might choose to consider their accounts through a post-colonial lens, following Spivak [43] understanding them as silenced subalterns in a world where hierarchies of difference and oppression, located in long-standing histories of economic, cultural and racialised inequality are internalised. Indeed the accounts we have been given provide rich evidence of the durability of colonial relations in a post-colonial world. What makes the situation less straightforward is that, moving across that world, these doctors have made a success of their careers, though not without a struggle as the quotes we've already cited suggest.

From their own accounts, and objectively within the medical hierarchy, they are members of a self-sustaining elite so far as the wider world is concerned, with children at private and public schools and following their parents into the medical profession. Yet within a marginalised specialty

like geriatrics those South Asian trained consultants without a regional or national presence or who have not achieve the position of clinical director may not be elite within the medical hierarchy. This complexity of status presents a challenge to the oral historian, given oral history's commitment to enabling hidden and marginal histories to be heard. The only extensive discussion of elite oral history, by Anthony Seldon and Joanna Pappworth, makes an uncritical case without uncovering much in the way of the problematics. A brief section, 'Interviewees' motives for accepting' hardly touches the surface of possible complexities [44]. Their preferred description of oral history as 'remembered conversation' is later criticised by Trevor Lummis who argues that this term only reflects the rather dismissive attitude to oral history amongst elites . Lummis argues that elites present difficulties because they are used to being in the public eye and being interviewed. They are, he suggests,

> *…adept at giving long answers which say little and of detecting the implications of a question and keeping to a consistent, but not necessarily honest line of answers…they are exceptionally self-conscious of what is revealed in an interview and practised at revealing only that which serves their immediate purpose.* [45]

The social science literature is no kinder to elites. Where most discussions relating to qualitative research methods draw on vocabularies of empowerment and empathy, the language changes when elites are discussed with terms such as 'obstruction, evasion, refusals' coming into play [46].

One of the few studies of elites using an oral history approach is Paul Thompson and Cathy Courtney's investigation into City of London bankers and financiers. In contrast with what I have suggested are traditionally negative perceptions of working with elites, Paul Thompson found that '…their openness varied a great deal according to individual personality' and that '…some informants remained cautious throughout,

always presenting the kind of public front which would also be available in the written record, while…others talked astonishingly freely, even about major scandals in which they and their banks had been involved'[47].

So it seems that elite members may be human after all, they vary and they may sometimes be unexpected in their responses. Listeners may need to change their expectations of how elites speak. The interviews with South Asian doctor are no different. Given an opportunity to reflect and evaluate their experience some spoke with what felt like candour, others were more reserved giving what amounts to an official narrative. And, like the City of London bankers, some of their testimony is openly critical of colleagues, at times bordering on the defamatory. Of course it is highly likely that our interest in their careers may have encouraged more frank responses, suggesting that members of elites, just as others, may respond well to interviews which make approaches which are empathic and empowering in intent. And it may also be the case that the differences obvious amongst us as a team of researchers, one being South Asian, one black British, the third white British and over 60, encouraged disclosure and a preparedness to talk freely amongst some of our interviewees. We may feel more certain about this once we have completed more interviews.

Stoler & Strasser in a discussion of the memories of Dutch colonialists and Javanese servants argue for explorations which question both ‘the colonial’ and ‘colonial memory’ as ‘known and knowable quantities rather than as problematic sites of inquiry in themselves’. Ultimately they question assumptions about the nature of colonialist memory-work as well as assumptions about the extent to which the colonial persists in post-colonial lives[48]. Similarly to speak about racism, either as an

interviewee or as a researcher may mean setting on one side ways of thinking that are caught up within a legalised binary politics, depending on overt and somatically observable and experienced definitions of racism. Under such conditions racism cannot easily be spoken. However, by identifying a particular migrant group as doctors with a history of contribution to the development of a specialty, we may be contesting the silencing of racism within medicine, and specifically the politically silencing category 'overseas-trained' [49]. By hearing the specificity of experience and the detail of individual life stories we aim to avoid intellectual silencing by presenting the words of those interviewed even when this may mean that our assumptions and expectations as researchers are contested in the reflections and accounts of the researched.

Conclusion

In exploring the experiences of South-Asian overseas trained doctors and their contribution to the development of geriatric medicine we have looked at ways in which their accounts illustrate the articulation of difference and discrimination, focusing specifically on how racism. In doing so we have discussed evidence from an emerging set of interviews in relation to the literatures of migration and elite oral history.

These accounts are rich in content with details of medical training, twentieth century geriatric care and, of course, the lives of skilled migrants coming to the UK. The interviews we have so far read present a consistent narrative of working in a marginalised medical specialty, of gaining entry to an employment situation where local candidates are favoured over migrants, where the interplay of these two factors leads to a career in geriatrics and the where success depends on hard work, sacrifice and support from a senior mentor or patron. Reading from the transcripts is a reminder of the ways in which past and present articulate in the narrating of accounts of personal experience. However, as examples of the presentation of experience we want to draw attention to three ways in which they are layered.

First is the way in which these interviews are the result of an interaction between two people where what is spoken is affected by the speaker's notion of audience, the identity of the interviewer and the purpose of the exchange. The South Asian doctors were invited to talk about their careers and so their understanding and intent appears to be truth-telling. They have a personal and professional story to tell, one that is in part knowable from other sources and therefore publicly available, for example from medical publications, and membership records. At the same time their interest lies in establishing themselves as successful in their lives' trajectories. These are personal accounts which are unlikely to have been told previously so completely, and nor for archiving purposes. Our second layer draws attention to hearing what they have to say within a context which denies any simple articulation. Looking back at experiences of racism they tend to choose to smooth over what might in the present context be positioned in much more accusatory language. In the UK, so far as patients and the lay public are concerned, and from their accounts racist expressions are seen as a part of everyday life. However, when delivered by colleagues, usually indirectly, racism is less likely to be overlooked. This might be interpreted as silence. We instead suggest that these ways of explaining and recounting need to be heard within a broader context of differences and hierarchies.

Finally, our third layering highlights the performative nature of talk in an interview. For oral historians the interview is always more than the recorded and transcribed words, it is a process in which the narrator, the interviewee, is actively constructing and creating an account. Under such conditions their subjectivity is produced and presented both for themselves and for their audience. Though the doctors we interviewed displayed well-honed professional skills and occupied elite positions within the NHS medical hierarchy the positioning of the geriatric specialty and their accounts of their career development complicated the ways in which these accounts were presented to the interviewees. At times in the interviews it seems that the discrimination and inequities attached to the status of geriatric medicine were being used to speak for,

or to subsume, experiences of racism. And of course, the complicity of the interviewer in the construction of an account might also contribute to the performance. For some the interviewer might be perceived to be sharing an experience of racism while for others seen as dredging up discomforting past experience.

The intertwining of a migrant and an elite status in the life on an individual and the invitation to tell to an immediate audience and for posterity leads us to suggest that the difference between elite and non elite is not sustainable. These doctors' accounts provide evidence that there were moments and contexts in which they were less elite. These moments are difficult to voice in the context of being part of an elite formation where the identity that we explore, that they express and they are encouraged, indeed wish, to inhabit is that of elitism. In fact, they undermine the distinctions between elite and non-elite that so much interviewing has come to consider commonplace. For our study we note that in such circumstances it may be threatening to encourage talk of non-elite aspects and indeed a disservice to some to impose racism on their utterances. The request not to 'mix race with the specialty' needs to be heard with this understanding.

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