Overseas-trained South Asian doctors and the development of geriatric medicine

Findings

Migrant doctors have provided a significant contribution to the NHS workforce over the last 60 years yet their presence has been largely undocumented and their achievements unrecognised. Making good this deficit, researchers at the Open University have carried out 60 oral history interviews with retired and serving overseas-trained doctors from South Asian countries about their experiences of working as geriatricians in the UK National Health Service from 1948 to the present day. This ESRC funded project also links with an earlier project, carried out by Professor Margot Jefferys: ‘The pioneers of geriatric medicine’.

Key points

- Doctors coming to the UK from South Asia were taking part in a long-established tradition of movement in both directions for medical training.
- Working in the NHS was seen by many as an opportunity to practise in a system of health care provision which they perceived to be fair and equitable for both patients and doctors.
- Between the 1950s and early 1980s geriatric medicine was known as a ‘Cinderella specialty’ as it was not highly regarded by UK trained doctors.
- Nevertheless geriatric medicine offered opportunities for career progression to both the early geriatricians and the South Asian doctors.
- South Asian doctors encountered discrimination in their attempts to progress through the hierarchical system of the medical profession.
- Both the pioneers and the later South Asian geriatricians worked to change the quality of health care available to older people in the UK, emptying the old workhouse wards and introducing medical interventions which rehabilitated those who had previously been denied treatment.

Methods

The project team, Joanna Bornat, Leroi Henry and Parvati Raghuram of The Open University interviewed 60 retired and serving South Asian qualified doctors employed by the NHS in England and Wales. Participants were recruited through networks of overseas doctors, through the British Geriatrics Society and through snowballing. The interview schedule used a life history approach, starting with childhood and education, going on to medical training, migration experience, working in geriatrics and career development in the NHS. The interviewees had obtained their initial medical qualifications in India, Bangladesh, Sri Lanka, Pakistan and Burma and at the time of the interview ranged in age between 40 and 91. All except two were, or are, consultants and some also held academic posts as professors. Along with Gail Wilson of LSE they also reanalysed an earlier set of interviews carried out by Margot Jefferys and colleagues in 1990-91 with 54 doctors who pioneered the geriatric specialty. In addition, the project made extensive use of documents lodged in the National Archive as well as in archives relating to the medical profession. The new set of interviews will be lodged alongside the Jefferys interviews in the British Library.
Historical migration pathways

The doctors interviewed were following a long-standing tradition of movement between South Asia and the UK. Development of a medical career often involved experience of overseas work. Amongst the geriatricians interviewed by Professor Jefferys were several who had lived and worked in India during the colonial period while the South Asian doctors also remarked about their teachers that:

Most had Royal College qualifications. So either they were MRCPs, FRCPs or FRCS. Nearly everyone had that ... I suppose most Indian doctors would come to the UK. With the two hundred years of the British Raj - and don't forget I'm one of the Midnight's Children. I was born in 1946 so it's just before Partition. So, the British influence was very much in the family and it was sort of ingrained. And then when you see your teachers they all had their British degrees behind their names ...

(LO47, born in Bihar 1946, arrived in UK 1972)

NHS dependence on overseas-trained staff

From its inception the NHS has depended on recruiting staff from overseas. Since the 1960s race and immigration have been politicised. Immigration legislation in the 1960s and 1970s targeted migrants from the Commonwealth countries. However, new legislation on racial discrimination in employment (enacted in 1976) and concern about the cost of the NHS and staff shortages also influenced doctors' career opportunities.

In this context doctors can be seen as a mobile army of labour, particularly in the lower rungs of the medical hierarchy and in the less popular specialties, amongst which was geriatrics. A crisis of staffing from 1960s meant that by 1974 over 60 per cent of consultant geriatric posts were filled by overseas trained graduates. By way of comparison between 1964 and 1991 overseas trained non white doctors made up 3 per cent of consultants in general medicine and 9 per cent of all NHS consultants.

However, these developments were not always viewed positively:

... the present pattern of education of medical students, nurses and other health personnel in Britain does not reflect the needs of this high risk group ... so that elderly people have grave difficulties in attaining the Health Care appropriate to their needs ... This concentration of Overseas Graduates in what remains a low status specialty is undesirable on many grounds and for the future it is not clear that plans for future expansion cannot be based on the assumption that the supply of such Graduates will continue. (Professors of Geriatric Medicine, writing to the Royal Commission on the NHS, 13.12.76).

Perceptions of NHS system of health care

Contrastingly, many of the doctors interviewed expressed great enthusiasm for the NHS. For some it matched their own value systems:

So and then I knew I had to now I had to stay here. And I was never going back. I had a lot to go back to, wealth, position, knowing people. I would have risen there then much better, financially much better ... I hope they don't change it ... if they do change it after I'm dead. There is no institution like National Health.

(L028, born in Bombay 1927, arrived in UK 1953)

At the same time they appreciated differences in the ways doctors worked:

And I had a very good relationship with the Ward Sister ... here we saw nurses more or less as equal and they were not subservient and you asked for their opinion about things that they were good at. You didn't tell them, you asked them. In the Indian scene ... doctors were only for doctoring and so a lot of things, even maintaining notes, we had in our hospital, we had a separate person like a clerk who went round with us and wrote down in the notes, medical notes.

(L022, born in Bangalore 1945, arrived in UK 1973)

Reputation of geriatric medicine

Geriatrics was known as the ‘Cinderella’ specialty. In the early days of the NHS, care of older people with chronic conditions was little more than tending and took place in the back wards of large municipal hospitals, ex Poor Law infirmaries and cottage hospitals. Patients might go for years without seeing a doctor and were often confined to bed permanently. The founders of the geriatric specialty attempted to change this situation, in part as a more humane approach to medical care and treatment in late life but also in response to a demand to find ways to release hospital beds for use by other patients.

The South Asian doctors soon became a part of all this and their accounts provide testimony both to attitudes generally and towards older patients:

Geriatrics came to occupy as a second class doctors doing second class service for second class clients. I would not accept that. When I first started becoming a consultant I started here. I used to get great wad of letters, ‘Will you kindly see this patient and advise’.
They bloody well didn’t want my advice. They wanted me to remove the body blocking their beds. And I said to myself; ‘I will never become a clinical undertaker. Never. I have learned some medicine and I want to practise it’.

(L028, born in Bombay 1927, arrived in UK 1953)

This struggle to be recognised is also reflected in the Jefferys’ interviews:

But it’s just a few years ago that I sat next to someone on a plane and we were going to a cardiology meeting and he was a cardiologist and he assumed I was – I didn’t enlighten him. We got talking about things and he said to me ‘Well, of course, my definition of a geriatrician is a doctor who is not good enough to be let loose on patients who matter’. It isn’t all that long ago …

(Dr Grimley Evans, born in UK 1936, Jefferys interview)

Such attitudes drove a strategy that saw the recruitment of marginalised groups of doctors such as GPs, women returners and migrants.

**Geriatrics as a site for progression and promotion**

The doctors interviewed found that opportunities for career progression tended to be limited by NHS professional hierarchies – even today more than twice (42%) as many white as overseas non white (17%) doctors are consultants in the NHS. Geriatrics, did, however, offer a way to progress. Many of those interviewed followed the pioneers in this respect, often taking the advice of senior colleagues as this doctor recalls:

Because my consultant, who was exactly like me... 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’.

(L023, born in Madras 1958, arrived in UK 1996)

But professional advancement was not always the whole story – also important was personal achievement for both doctor and patient:

... it took me five years but I got him back to work … And got him back to work. I’m not joking, I cried that day. I cried that day when that fellow – he was a butcher – I got him back to work.

(P023, born in Kerala 1941, arrived in UK 1968)

**Experiencing discrimination**

The South Asian doctors talked not only of the stigma of working in geriatric medicine but also of personal encounters with discriminatory practices. They tended to focus on three areas where, as outsiders, they experienced discrimination: in getting their first post in the UK; when attempting to get a post as a specialist registrar; and in the allocation of discretionary merit awards and national positions as consultants.

Some picked out particular instances where interviews were unfairly conducted, promotions denied and work went unrecognised:

... when I first came (to the UK) ... 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.

(P021, born in Sri Lanka 1944, arrived in UK 1973)

Opportunities to secure promotion in the more popular specialties were few, even for experienced, well qualified doctors as preference seemed to be automatically given to UK trained doctors:

Well chances were nil. I mean let us not beat about the bush. In those days if in an interview you found a local graduate you might as well walk off. But you could only get if there were more than one or two, three posts and you were competing amongst yourself’.

(L035, born in Haryana, 1947, arrived in UK 1975)

Many found it difficult to secure posts in London and the south east and instead opted to work in more peripheral areas such as the northwest and Wales and in non teaching hospitals where there was perceived to be less competition from UK graduates:

I started applying for senior registrar ... so I applied in cardiology in Birmingham, in London. I made a mistake. I should have applied in North East, I would have got in, but I didn’t have the patience. So I went there but they are all ... you are competing with white boys.

(L032, born in Bengal 1940, arrived in UK 1969)

Those interviewed were nearly all consultants and one way of measuring their success was through the receipt of merit awards. These were four tiered financial awards given to consultants on the basis of recommendations from local, regional and national...
senior colleagues. They reflect the esteem and status of individual consultants and the highest award could double a consultant’s salary. Throughout the period of our study it was well established that both South Asians and geriatricians were far less likely to receive merit awards than white doctors in other specialties: I think the main reason, without trying to be critical, is that the geriatricians had a hard, heavy, workload, clinical workload and had little time left to do other extra work, like research, publications and in terms of giving awards these other aspects were given more importance than the guy who was providing sort of a bread and butter service, working hard from morning till evening. I think that’s the main reason really. And without trying to be cynical, maybe old schoolboy ties and that sort of thing. (laughs) can play a part. But I better not say anything more than that. (laughs) Very few South Asian geriatricians also received recognition at a national level: We used to joke that go to the annual general meeting of BGS (British Geriatrics Society) it’s like Indian Medical Association really. It is still like that you know. South Asian doctors have run the NHS really isn’t it? If you take general practice or, I mean, like our hospital here, probably thirty per cent are South Asian. NHS was about thirty/thirty five per cent South Asian. So there’s a massive contribution really … The only South Asian doctor was Dr Banerjee who was the chairman of the BGS and then there’s a couple of doctors in Wales, Dr Sastry and Dr Bhowmick. They are the ones who are quite high up at the College level or at the national level and all that, you know, but very few … But it doesn’t represent thirty per cent of the population of South Asian doctors really. (laughs) The accounts they give suggest the need to understand discrimination and racism in the NHS as complicated by racism, the stigma of types of patient, competition for resources and the role of senior individuals acting as sponsors and supporters.

Developing service provision

Developing service provision in hospitals often meant struggling for resources for the care of older people. The idea of age-related admission to a unit which focused exclusively on older patients was one way forward, with doctors, nurses and medical students trained in old age medicine. Collaborations with GPs, social workers and other professionals were also seen as essential to improving service provision. However, the tension between providing an integrated service and one that focuses on acute care has never been resolved: … if people try to downgrade my specialty I stand up to them and say ‘Tell me in what way my doctors, or my nurse, or myself, is inferior to you’. Which there is a – say if you are a one organ specialist, cardiologist for example, you consider yourself to be elite. And I say ‘Nothing is elite. No work is less important in my view. So if I am treating older people they are no less important than if you are treating a person with a heart problem.’ And geriatric medicine is the last of the frontier of general internal medicine. It is going now. In fact now I am a Royal College Examiner and we examine candidates and those who have done geriatric medicine tend to do much better in the examination because they have done proper clinical examination on the patient. They know how to sort out a frail patient, which many other people have not been exposed. And I think all physicians should be exposed to a part of their training in geriatric medicine in my view.

Relevance today

In this research we have focused on the experiences of migrant doctors through the second half of the twentieth century. Today, many of the issues that face the NHS and its doctors remain very similar. New immigration rules exclude non-EU doctors from training in the UK but the introduction of the European Working Time Directive has led to staff shortages, reminiscent of the earlier period. And of course, the care of older people, amongst whom will be the South Asian geriatricians, continues to be pressing. It is within this context that this project makes a case for the need to recognise the contribution which international medical migrants have made in the past and can continue to make to the NHS.

For further information see http://www.open.ac.uk/hsc

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