Introduction: writing the history of the 'International' Health Service

The histories of the National Health Service (NHS) and of British general practice are profoundly intertwined with the history of the imperial legacy and of medical migration. This book shows that the NHS, which was established in 1948, would not have been what it had become by the 1980s without being able to draw on the labour of migrant South Asian[1] doctors. When it comes to the history of the NHS, the migration of South Asian doctors cannot be treated as a side issue. An appreciation of its importance is essential to our understanding of the history of British healthcare. These doctors made it possible for British general practice to take on a role as the so-called 'cornerstone' of the NHS, the function of which was to control access to other (more expensive) treatments and provide care in community settings.

By the 1980s, over 4,000 general practitioners (GPs) working in the NHS had been born in India, Pakistan, Bangladesh or Sri Lanka.[2] They accounted for around 16 per cent of the GP workforce[3] and were the first point of contact in the UK's healthcare system for one-sixth of the population—some nine million people.[4] These GPs were overwhelmingly concentrated in parts of Britain that the majority of locally trained doctors deemed less attractive. In the early 1990s, over half of the GPs working in Walsall, an industrial town in the English Midlands, had qualified in South Asia. In predominantly rural Somerset in the South of England, the equivalent figure was of less than 1 per cent.[5]

South Asian GPs were instrumental to the delivery of care in industrial and inner-city areas. Their presence was a central dimension of the working class experience of healthcare. M. A. Salam, a GP who worked in a mining community in South Wales, thus told me of the surprise of one of his young patients at encountering a white doctor for the first time: 'One little boy was

born in my practice. He saw me all the time and at the age of ten he had to go to hospital for tonsillectomy … When British doctors came to see him he was astonished: he thought all the doctors look like Dr Salam!'[6]

This account of a patient seeing a Bangladeshi doctor as being a member of something akin to a caste of practitioners at the service of the NHS is illustrative of the extent to which South Asian medical graduates were key to the functioning of the British healthcare system. Practitioners such as Dr Salam were working with populations that had historically found access to medicine difficult and that the NHS had been set up to serve, in a field that brought them in contact with a broad cross-section of the population. Aneurin Bevan, the radical Welsh politician who, as Minister of Health, presided over the introduction of the NHS, talked about the need to root out the 'evil' that was the link between the provision of medical care and the ability of the patient to afford it.[7] The establishment of the NHS sought to remove this barrier by making access to care free. Recourse to migrant labour enabled the British government to achieve this aim.

In the chapters that follow I explore the impact that South Asian migrant doctors had on British medicine and more generally British society. In so doing, I seek to draw on history's ability to inform our understanding of the present and to contribute to a reflection around the role of immigration in modern Britain. The marginalisation of migrants in historical accounts of Britain's past is not just an unfortunate oversight that deprives us of a better understanding of a particular dimension of history. It supports contemporary political narratives that construct migrants as outsiders and obscures the fact that migrants have been essential to the functioning of the societies in which they live.[8]

This is not to say that this is a celebratory history: it engages critically with archival evidence and oral history interviews in order to offer a new perspective on the history of the National Health Service. Whether the NHS's reliance on migrants is a cause for celebration or not is debatable. For instance, I highlight the fact that many British-trained doctors shunned general practice in areas where demand for healthcare was greatest and show that local populations were served by marginalised doctors who moved into these roles because of a lack of alternatives. This does not offer an ideal model of how to run a health service. Moreover, although South Asian GPs worked in areas of great need, it could be argued that there was an even greater need for their medical expertise in

their countries of origin. The point is that we should recognise that the transnational movement of doctors fundamentally shaped an important dimension of life and death in post-war Britain.

In the following sections of this Introduction, I begin with an outline of how this study builds on current understandings of the histories of the NHS, empire, migration and more specifically medical migration. I then explain the rationale behind my focus on South Asian GPs during this period and go on to discuss how the study was conducted, as well as the conception of history which underpins it. I conclude by outlining the structure of the book.

Putting imperial legacies and medical migration centre stage

Around a third of doctors in the UK today are overseas-born.[9] Migrant nurses and other healthcare workers have also been instrumental to the development of the NHS since its establishment.[10] The role of medical migration has however remained marginal both to accounts of the organisation's development and to work on the history of general practice.[11] Historians of South Asian immigration and of the impact of the imperial legacy on life in Britain have for their part devoted little attention to the post-war migration of doctors.[12]

Approaches to the history of the NHS are not untypical in marginalising the impact of migration. Over the last thirty years, historians working within academia and beyond its confines have simultaneously highlighted the importance of empire and international population movement to the history of the UK and other European nations and critiqued the lack of attention that has been devoted to it.[13] Alexandre Afonso has thus drawn attention to the relative lack of scholarly research into the history of Portuguese migrants in Switzerland and has noted their over-representation in areas such as hospitality and construction.[14] Leo Lucassen has written of the absence of 'Ellis Islands' (i.e. spaces that explicitly recognise the historical importance of immigration in European countries) and attributes this state of affairs to European preoccupations with notions of stable and homogenous nation states that have influenced the work of historians.[15] Tony Kushner offers a not dissimilar argument regarding forced migration in his book *Remembering refugees: Then and now* where he notes the lack of historical attention

paid to the movement of some 250,000 Belgian refugees to Britain during World War I and contrasts it with what he calls the 'near obsession' with racist and fascist groups in British history.[16] Gérard Noiriel has shown how discussing migration as an internal dimension of the development of European nations rather than an external part of contemporary societies can serve to fundamentally reframe historical understandings by pointing out that between World War II and the late 1980s, immigrants to France built half of all new housing and 90 per cent of the motorways.[17] The silences of NHS history are symptomatic of what Noiriel has described as a 'collective amnesia' with respect to the role of immigration.[18] Of course, histories of migrants are being written, but as Panikos Panayi has pointed out, the need to ground wider histories in an understanding of population movement is still not widely appreciated by the mainstream of British academic history.[19]

Recent work pertaining to Britain has shown the utility of adopting the type of perspective that Panayi has argued for. Anandi Ramamurthy's work on British Asian youth movements and Linda McDowell's research into female migrants in the British workplace show that there is much to be gained by looking at the interaction between migrants and their social environments, rather than focusing exclusively on culture, experiences of exile and generally what makes migrants different.[20] Jamil Sherif, Anas Altikriti and Ismail Patel have further contributed to our understanding of these questions by exploring the impact of Muslim voters and organisations on electoral participation in British general elections.[21]

Naturally, if migration has tended to remain marginal to the preoccupations of historians in British and European contexts, other historical traditions have taken different approaches, which can support a shift in perspective when it comes to British history. Whilst the American paradigm of the 'nation of immigrants' is not unproblematic and can serve as a basis for the exclusion of certain groups (not least those who were forced to migrate as slaves) it has nevertheless compelled historians to engage with migration as a key dimension of US national histories.[22] In Argentina, international population movement is portrayed as a central dimension of the country's economic development.[23] Similarly, in Australia and New Zealand, migration appears more naturally as part of national stories.[24]

The growing body of transnational history has also contributed to further enhancing our appreciation of the need to pay greater attention to population movement, its effects and its regulation. Of particular relevance to the specific context discussed in this book, Anna Greenwood and Harshad Topiwala have shown how taking a transnational approach to the history of medicine and empire can bring to light the neglected roles of particular groups of physicians such as Indian doctors in Kenya under British rule.[25]

This study also builds on historical work which has underscored the importance of what Andrew Thompson refers to as the 'after-effects' of empire in contemporary Britain—in other words the ways in which the history of empire and colonialism has left its mark on present day society.[26] Georgina Sinclair and Chris A. Williams have demonstrated how the development of policing in Britain was influenced by colonial law enforcement, and argued that more attention should be paid to such concrete effects of the link between Britain and its empire.[27] Richard Whiting has made the case for the need to consider British politics and in particular the role of Britain in the world in the light of attitudes and perspectives connected to imperial dynamics.[28] Roberta Bivins has linked new approaches to imperial history to the history of the NHS by examining the ways in which responses to different patient groups influenced the development of healthcare in post-war Britain.[29]

This book adds to our understanding of the after-effects of empire by documenting their impact on the development of the British medical profession and therefore the structure of the NHS. Understanding modern Britain involves exploring the extent to which it has been and continues to be shaped by its imperial past. As Antoinette Burton has noted, this requires engaging with Franz Fanon's contention that Europe is literally the product of the Third World.[30] Drawing on the insights offered by these different strands of research enables a revisiting of the history of South Asians in Britain as a central part of the national story and can support the emergence of an alternative narrative of the making of modern Britain.[31]

The significance of the international movement of doctors

Although overarching histories of the NHS tell us little about the role of migrant doctors, since the beginning of the twenty-first century, researchers have started to recover the history of migrant doctors in

the NHS and have provided indications of how this task might serve to shape our understanding of the history of British healthcare. An essay published in 2007 by Aneez Esmail[32] set out a clear research agenda along these lines. He pointed out that although approximately a third of doctors practising in the NHS are from overseas, very little is known about their contribution to British medicine and to specific fields such as geriatrics, psychiatry and general practice where many of them found work. Esmail also outlined the importance of understanding the impact of discrimination against migrant doctors and of the legacies of empire on the development of healthcare provision in the UK.

Some answers to these questions have since been provided by oral history research on migrant South Asian geriatricians. Geriatrics formed a professional niche for South Asian doctors who exploited the unpopularity of the field of geriatrics to build careers in an organisation where they faced discrimination.[33] The specialty thus developed in a social context where both migrant practitioners and ageing patients were marginalised.[34] As one South Asian doctor put it: 'without racism there would be no discipline of geriatrics'.[35] Research on black and minority ethnic healthcare workers employed in the Manchester area between 1948 and 2009 provided additional evidence that migrants were essential to the staffing of the NHS in (post-) industrial northern cities: in 1972, over 80 per cent of doctors occupying the junior medical position of senior house officer in the Manchester Regional Hospital Board's area were from overseas.[36] Their testimony bore witness to their ability to engage with and shape the environments that they found, by setting up specialised clinics or simply through choosing to build careers in the NHS rather than leaving the UK.[37] The memoirs of a small number of doctors and of at least one doctor's wife contain additional evidence of the individual and collective roles of South Asian medical migrants.[38] Film makers,[39] community groups[40] and the race equality think tank the Runnymede Trust[41] have also explored this topic in ways which underscore the importance of this history and its relevance to ways in which we think of migrants in the present day.

Work on other groups of medical migrants in the UK and elsewhere also hints at the relevance of their professional trajectories to the development of global healthcare. Medical migrants are numerous; there is

also evidence that in different locations and at different points in time, they have tended to cluster in particular roles and specific geographical areas. Several thousand medical refugees from Nazism settled in the UK and were an important part of the NHS workforce when it was launched in 1948.[42] They faced obstacles, including xenophobia and anti-Semitism, but also played a structural role in providing care to other Central European migrants and in some cases made significant contributions to medicine: Max Glatt, for example, was a pioneer of the rehabilitation of people with alcohol dependency.[43] According to Paul Weindling, specialisms such as psychiatry and pharmacology were particularly 'accommodating' to refugees.[44] Refugee doctors were in some cases directed towards locations in British colonies and dominions such as Newfoundland, Hong Kong or Burma that were seen as remote and where there was an undersupply of doctors.[45] Just over two thousand Irish general practitioners were working in Britain in 1965.[46] Alongside Scottish-trained doctors, they were often to be found working in general practice in industrial English cities.[47]

The United Kingdom is far from unique in being dependent on migrant medical labour. In 1972, 140,000 of the world's doctors were not living in the country they had been born in, with three quarters of these medical professionals working in the United States, the United Kingdom, Canada, the Federal Republic of Germany and Australia.[48] In 1997, 81 per cent of doctors in Saudi Arabia were migrants.[49] There is also evidence that the tendency for medical graduates who have moved from their country of origin to be disproportionately represented in the parts of the service that local graduates deem less desirable is not confined to the NHS. Indian doctors working in Riyadh reported being discriminated against when applying for managerial positions and being underpaid; the majority of them attributed this state of affairs to their geographical origins.[50] In Australia, services for the Aboriginal population and in areas far from major centres of population have historically relied on overseas graduates.[51] A study of medical migration to Canada between 1954 and 1976 found that less affluent provinces such as Newfoundland and Saskatchewan were the earliest and most active recruiters of migrant doctors.[52] Abraham Verghese's account of his work as a migrant doctor in deprived areas and 'under siege'[53] city hospitals in the USA paints a similar picture of

dependency on international medical graduates to provide services to the local population:

> The effect of having so many foreign doctors in one area was at times comical. I had once tried to reach Dr Patel, a cardiologist, to see a tough old lady in the ER whose heart failure was not yielding to my diuretics and cardiotonics. I called his house and his wife told me he was at 'Urology Patel's' house, and when I called there I learned that he and 'Pulmonary Patel' had gone to 'Gastroenterology Patel's' house. Gastroenterology Patel's teenage daughter, a first-generation Indian-American, told me in a perfect Appalachian accent that she 'reckoned they're over at the Mehta's playing rummy', which they were.[54]

This vignette provides us with an intriguing insight into the realities of medical provision in the Appalachian Mountain range on the east coast of the USA, which is, of course, the scene of some of the most entrenched poverty in the country.

It is to be expected, though, that as we learn more about different groups of medical migrants, we will also learn more about how their experiences varied across time and space and according to their nationality, gender, ethnic origin and other factors. John Armstrong's research into the migration of doctors from New Zealand to the UK and the advantages that they derived from this movement on their return in the form of involvement in medical networks provides an insight into the experiences of white doctors in the NHS and an indication that this history is not necessarily one of marginalisation and disadvantage.[55] Although doctors who migrated to Canada were initially over-represented in particular geographical areas, there is also evidence that they were able to forge careers in the more prestigious fields.[56]

As well as adding to the history of the NHS, this book is therefore a contribution to the development of a contemporary history of the international movement of doctors and to the understanding of the role of migrants in healthcare systems in the Global North.[57]

The making of the NHS: 1940s–1980s

General practice in the first 40 years of the NHS offers a particularly fertile ground where these questions of the impact of migration on the mainstream of society, the legacies of empire and the influence of

medical migrants on the development of healthcare can be explored. Up to the late 1940s, the NHS was but a political idea. By the 1980s, it had established itself as a pillar of British society. As I will show in Chapter 1, at the beginning of this period, general practice was seen as in crisis and marginal. By the end of it, it was an indispensable part of the NHS and key to its workings. The process of dismantling the formal British Empire began in earnest with the independence of India in 1947, and by the 1980s Zimbabwean independence had marked its virtual end. As the formal Empire was dismantled, shifts in immigration policy and the regulation of the medical profession made it harder for former British subjects to move to the metropole.

The movement of South Asian doctors to Britain cannot be properly understood without reflecting on the legacy of empire. During the decade that followed independence and the partition of India in 1947, South Asian doctors who had been trained in English in schools shaped by the British model of medicine were able to move relatively freely within the former British Empire. This freedom was gradually eroded by new immigration laws from the 1960s onwards; by the withdrawal of recognition of medical degrees awarded on the Indian subcontinent as well as the introduction of professional and linguistic tests in the 1970s and finally by the establishment of compulsory specialised professional training for general practitioners in 1980 (until then any holder of a medical degree recognised by the General Medical Council (GMC) could become a GP).[58] By the 1980s, the relationship between British general practice and migration from the Indian subcontinent had been radically altered. Doctors who had qualified when subcontinental degrees were still recognised or who had passed the required tests and successfully undertook training could still enter general practice. The impact of South Asian medical migration on the NHS and general practice was however no longer on the same scale. The number of South Asian doctors working in the UK grew dramatically during the first four decades of the NHS—from up to 1,000[59] immediately after its inception to 10,000[60] by the end of the 1970s, making them the main group of international medical graduates working in the NHS. The percentage of South Asian-born doctors in the GP workforce peaked in the 1980s before beginning to decline in the 1990s.[61] Between the 1940s and the 1980s, the NHS was taking shape and establishing itself as a viable healthcare system as opposed to a political vision. The fact

that it remains in existence today should not be retrospectively taken for granted: there was a strong current of opposition to it, which persisted throughout much of this period.[62] By the 1980s, the need to preserve the NHS had however become part of the political consensus.[63] Margaret Thatcher, whose governments were uncompromising about the virtues of wholesale privatisation in other domains, felt compelled to reassure voters that 'The National Health Service is safe with us'.[64]

I will show in this book that the NHS's ability to provide access to general practice services in all parts of Britain[65] was fundamentally dependent on the work of the South Asian doctors who contributed to its development as a field of medicine which was itself at the heart of the evolving structure of the NHS between the 1940s and the 1980s. As I will discuss in Chapter 1, general practice went through a period of fundamental change at this time, from being perceived as marginal to becoming central to the NHS and benefiting from an enhanced professional status. The College of General Practitioners was formed in 1952 and became a Royal College in 1972. Having been traditionally looked down upon by hospital specialists as the application of medical knowledge at a less in-depth level, general practice was by the 1980s formally recognised as a form of medical expertise in itself. It was also more than a newly defined specialty. Practitioners were at the heart of the British medical system. They managed care in community settings (thus containing the cost of specialised treatment) and controlled access to specialists in their role of 'gatekeepers'. GPs' direct contact with the population at large sets them apart from the majority of hospital specialists.[66] If a third of practitioners in a major urban conurbation were South Asian-born, this signifies that around a third of the people living in that area were dependent on these doctors as a first point of contact with the NHS. If it might be possible to argue that the NHS would have continued to exist in a recognisable form with, say, 30 per cent fewer geriatricians in a particular area, the absence of 30 per cent of GPs would have posed a problem of a different magnitude.

Writing an oral history of a 'marginalised elite'

The argument that I develop in the following pages is based on an analysis of the forty-five oral history interviews that I conducted in the course of my research and a diverse array of archival material. It is also founded on a conception of history which views it as having the

potential to enhance our understanding of society, rather than solely being concerned with interpreting the past.[67] In adopting this approach, I build on a tradition of historical scholarship that uses history to engage with contemporary questions.[68] As Eric Hobsbawm has noted, the flight of numerous historians from 'big questions' of social transformation towards culture, ideas and individual historical experiences is one of recent decades rather than a fundamental characteristic of social history.[69] He points out that historians can be stimulated not just by the methods used by social scientists but also by the questions they pose.[70] He attributes for instance the multiplication of historical studies of the British industrial revolution to the concerns of economists regarding the processes that shape industrial revolutions.[71] It should not be forgotten that E. P. Thompson's *The Making of the English Working Class*, one of the pioneering texts of British social history, was written, according to the author's preface, with a view to making a contribution to the understanding of class structures (through the examination of the history of ordinary people towards whom posterity had in his view shown 'enormous condescension').[72] In her preface to *Hidden from History*, her pioneering text of women's history, Sheila Rowbotham explicitly states that the inspiration for the book came from a desire to inform ongoing discussions about women's liberation.[73] It is worth restating that history provides useful tools for understanding the world that we live in and that using contemporary questions to formulate research questions has the potential to open up rich new seams of historical enquiry.

My work is also influenced by the arguments that a number of scholars have made in favour of the integration of historical perspectives into policy-making processes.[74] Virginia Berridge and John Stewart have argued that history is not necessarily solely concerned with the past and that it should also be seen as a social science that supports us in reflecting on social processes more generally.[75] As John Tosh has argued, history's emphasis on a holistic approach to evidence that unlike, say, economic or sociological research, is not informed by a problem-solving agenda driven by theory can serve to generate 'unexpected and illuminating' insights.[76] Historical reflection naturally offers a different perspective rather than clear instructions on how to proceed.[77] Its strength lies in its ability to generate different ways of thinking about current concerns.[78] Attempts to discuss history's policy relevance are of course subject to contestation and debate as is all historical knowledge. There

are moreover limitations to such an approach: in addition to questions around the nature of historical knowledge, the extent to which understanding can be transferred across space and time is subject to debate and decontextualised historical knowledge has the potential to be misused.[79] It remains that reference to the past is in any case made in the context of policy debates and that historians can contribute to these ongoing discussions by using their training to provide a counterpoint to more simplistic recourses to history.[80] What I offer here is therefore a critical history of a group of migrants that I believe speaks to contemporary immigration debates.

This agenda naturally shaped my approach to the research I conducted for this book. Oral history, which involves drawing historical understanding from an engagement with people who lived through a particular period, can play a crucial role in helping to understand the interactions between migrants and the social mainstream. This approach builds on Rob Perks's critique of what he describes as British oral historians' central preoccupation with histories of ordinary people to the detriment of 'elite oral history', which he describes as being viewed with 'deep suspicion'.[81] According to Perks, the political origins of British oral history as a radical alternative to histories of male elites make historians ideologically averse to engaging with those who cannot be described as 'voiceless'.[82] He argues that this helps to explain the lack of attention that British oral historians devote to business and corporate culture.[83] Sjoerd Keulen and Ronald Kroeze have built on Perks's argument to make the case for the relevance of oral history to leadership and organisational research.[84] As they put it, oral historians tend to pay insufficient attention to important historical actors who are viewed as 'elites' because there is a presumption that they have already had ample opportunities to make their voices heard.[85] Perks retains a dichotomy between elite and marginalised histories which can at times be problematic: South Asian GPs were at times professional leaders and socially influential but they were also marginalised and have tended to remain hidden from history. Alongside Keulen and Kroeze, he does however point the way to a different approach to oral history by encouraging oral historians to strive to develop what he describes as a 'better understanding of our wider society'.[86]

As is the case with oral history generally, the focus of much of the history of immigration to the UK on experience and identity can be

attributed at least in part to the intellectual roots of studies of migrant and black experiences conducted from the 1970s which were influenced by the emergence of a 'history from below' approach.[87] Cynthia Brown's analysis of recordings from the East Midlands Oral History Archives led her to conclude that it was time to 'move on from questions about settling in Britain or food and festivals to others that are more directly relevant to an understanding of experiences and relationships in the twenty-first century'.[88] She notes in particular that the influence of ethnic minority city councillors in Leicester is a subject that would merit detailed investigation.[89] It is in the fulfilling of this type of role that migrants might be described as marginalised elites. Medical migrants in some respects found themselves in subaltern positions but they also formed part of a group of professionals that was in a position to shape the NHS. Historians have much to gain from questioning the notion that there are rigid boundaries between the margins and the centre. Adopting this position supports the production of a more rounded account of the history of general practice and of the NHS, which incorporates the influence of marginalised practitioners on the development of the discipline and of British healthcare.

When assessing the ability of a group of migrants to exert influence on the system in which they were working, it is perhaps particularly important to be aware of the potential synergies between interviews and archival evidence. South Asian doctors have left traces in traditional archives as members of medical organisations, through the dealings that groups that they established had with government and as a result of their position in communities. They also preserved documents themselves in their personal or organisational archives and wrote to (and for) medical journals and the national media. Evaluating the impact of South Asian general practitioners on their field has therefore involved consulting a number of relevant sources such as newspapers, UK government records and the archives of professional medical bodies. The documents located in the process complement the interviews, providing details that many interviewees could not recall decades later and additional evidence of the agency revealed by participants' accounts of their lives. Interviews also served to help locate material in the archives, for instance when doctors discussed efforts to lobby government.

It is through a holistic engagement with this broad range of sources that a sense of how South Asian doctors contributed to shaping British

general practice was developed. Finding relevant archival documents that provided information about the specific nature of the roles played by South Asian migrant doctors involved consulting a wide range of material and gradually building up a picture of their influence by drawing on a range of qualitative material and relevant statistics compiled at different times. I came to the conclusion quite early on in my research that this was the only logical way to proceed. As will be apparent, this is not the story of an official programme to import GPs that was centrally monitored. Nor does monitoring the degree to which migrants were able to exert agency necessarily figure high on the list of government priorities. Doctors did leave traces in government records, studies were at times carried out to determine their numbers and migrant doctors were discussed in the medical and mainstream media but I am unaware of the existence of any official files pertaining to a systematic monitoring of their deployment and their roles. In this book, I am often interpreting a range of materials and seeking to make a case beyond reasonable doubt rather than attempting to offer some form of immediate 'proof' of my claims. I believe in fact that this rounded approach has ultimately served to provide a more accurate picture than simply relying on government records and other official documents. For instance, as I will detail in this book, the Home Office during this period was publishing statistics on the migration of doctors that at least one of its officials believed were deliberately misleading.

It should of course be recognised that by proposing an interpretation of the past based on a human interaction located in the present, oral history is undoubtedly engaged in a task which differs from the endeavours of historians who remain solely focused on documents. This should naturally lead to a reflection around how best to conduct interviews and engage with their content. Kirby provides a useful summary of some of the main issues involved in collecting and analysing these data:

> How can the interviewer ask relevant, informed questions yet still provide an atmosphere that will not improperly influence the informant's responses? How can the historian evaluate the responses of the informant, which can be tainted in a variety of ways? And related to both of these is the larger issue of the objectivity or subjectivity of all historical data, indeed of all historical knowledge.[90]

Kirby's point about the relative nature of all historical knowledge is key to the oral history approach used in this study. Dealing with such concerns in respect of oral history is a not dissimilar process to the one advocated to make the broader case for the value of a historical approach in the context of this study. The historical methodology which has been adopted here involves essentially treating other sources such as printed materials with just as much caution. If the relationship between interviewer and interviewee can shape the content of an interview, then decisions made by historians when using archival material, the availability of material and the choices made by those who produced the documents equally shape the context and therefore the content of their work. Interviews contain statements which can be evaluated and provide information in the way that other sources do. If historians are able to critically engage with written sources as subjective as the records of the Inquisition or police reports on youth movements and produce historical accounts that are deemed credible, the same principle can be applied to oral sources.

The attachment of some historians to documentary sources over oral sources can in fact, as Pat Thane has pointed out, be seen as paradoxical, particularly given that many written documents are themselves reliant on oral sources or memory.[91] Paul Thompson, whilst recognising that all recollections are subjective, emphasises the relative nature of such concerns, mentioning that much of the process of memory shaping takes place in the immediate aftermath of an experience, thus influencing contemporaneous documentation such as newspapers, correspondence and official reports.[92] He also notes that oral history has the advantage of being able to engage with protagonists who may well express themselves more frankly as a result of the passage of time.[93] In addition, one of the neglected contributions that oral history makes to history is that it often enables researchers to gain access to printed material that has been preserved by individuals and would otherwise not have been available.[94] Oral sources can be used along with other sources, with the interaction between the two leading to the gathering of additional information and the development of new lines of enquiry.[95] The approach to oral history adopted here therefore involves seeing it as a natural component of a contemporary social history aimed at enhancing our understanding of the past and of the present through what Thompson describes as 'reconstructive cross-analysis'.[96]

It is also open to the insights that the subjective engagement of participants with the research project might produce and to drawing on the subjective nature of memory as a resource.[97] As Alessandro Portelli has argued, even factually inaccurate statements can contain a psychological truth that can be just as important as any narrative based on established facts.[98] Kirby's advocacy of the recourse to phenomenological principles (which focus on perceptions of the world) in oral history provides a useful reminder that:

> When the informant's memory seems vague or unreliable, the interviewer keeps in mind that all the 'real facts' cannot be known under even the best circumstances and looks rather for truths of understanding, of spirit, of cultural values, that tell the story of the historical event or era … often the goal should be to suggest possibilities rather than draw conclusions.[99]

This is not to say, as Portelli himself has pointed out, that oral history should be solely defined as an exercise in analysing subjectivity.[100] It also reveals 'unknown events or unknown aspects of known events'[101] and casts 'new light on unexplored areas of the daily life of the non-hegemonic classes'.[102] Both of these dimensions of oral history are relevant in the context of gaining a greater understanding of the role of South Asian doctors in the development of general practice and the NHS. They have enabled me to explore the interface between medical migration and the development of the British healthcare system.

At times, engagement with subjectivity predominated and I have drawn historical understanding from themes that emerged from the interviews. This was the case for instance when it came to reflecting on the ways that doctors described their relationship to the UK or with their patients (see Chapters 3 and 6). In other cases, I have heavily relied on contemporary media coverage or archival research, such as when trying to understand the evolution of British general practice and of migration policy (see Chapters 1 and 2). Elsewhere, oral history is interpreted alongside archival evidence. Although there was at times a greater reliance on one or the other, I viewed interviews and archival research as forming part of the same process that served to cast light on a past I was seeking to better understand. The conclusions of this research are therefore founded on an exploration of a range of evidence

examined critically in different ways with the aim to gradually develop an understanding of the question being explored. Theory in this context was used when appropriate to provide an explanatory framework, for instance when using the concept of 'dirty work' (i.e. work that is perceived as lacking in dignity and prestige) in the context of medicine to understand how migrants came to be over-represented in particular roles or referring to 'heterophobia' (i.e. hostility towards difference) to seek to understand the discriminatory environment provided by the NHS.[103]

The findings presented here are based on forty-five oral history interviews (forty with South Asian GPs and five with other witnesses to this period, i.e. two medical politicians and three children of South Asian GPs) and extensive archival research (a list of sources is included in the bibliography). I sought to avoid being over-reliant on particular personal and professional networks and aimed to speak to male and female doctors from different parts of the subcontinent, who had worked in different parts of Britain. I recruited participants through various means, from attending gatherings of South Asian doctors to using the internet to locate doctors whose names appeared in the course of archival research, recourse to medical directories and reliance on personal contacts of people who agreed to participate. Obtaining consent to participate involved a negotiation process and in order to encourage participation I frequently promised to limit interviews to around ninety minutes—sometimes one hour in the case of doctors who continued to work long hours. This inevitably shaped the interviews as with limited time I tended to devote most of my questioning to doctors' lives and careers in medicine, which was the central focus of my research. At the end of the interviews participants were given the opportunity to frame a photographic portrait of themselves in a way that they felt represented them appropriately, choosing the setting and background. I believed that this would be a useful exercise in that it would produce a photographic record of the first generation of South Asian GPs to work in the NHS but also that doctors' engagement with this exercise might help cast light on the history I was researching.[104] All but three of the doctors interviewed received their initial medical training in the Indian subcontinent. I chose to not exclude South Asian-born and British-trained doctors from the study as I felt it would be useful to

record their experiences and reflect on the extent to which they differed from those of their South Asian-trained counterparts. I also wanted to explore connections with pre-NHS medicine: the British-trained doctors I interviewed were all children of South Asian GPs. My aim in interviewing South Asian doctors was in any case not to claim that they formed a homogenous group; they clearly differ in many ways. It was rather to explore how the fact that the mainstream constructed them as different contributed to the development of medicine in the UK. When participants asked to remain anonymous, I refer to their quotations as being from an anonymous participant. I have refrained from the temptation to use different names or assign participants a number in an effort to ensure they cannot be recognised in a study that draws on biographical information. Some readers might for instance have been able to make an accurate educated guess concerning the identity of 'participant number 20' based on the content of several interview extracts that are attributed to the same person (i.e. one that identified them as having been active in local politics, another saying they trained in Calcutta and yet another detailing their passion for sport). A note finally on the transcripts of the interviews which accurately reflect the words and expressions used by participants. I have used ellipses (…) to shorten passages and when people hesitated or stumbled on words. I have however refrained from anglicising extracts of interviews, preferring to remain faithful to the South Asian English used by many of the people I spoke to.

The chapters

The book is divided into three parts.

The first two chapters place the history of migrant South Asian doctors in its wider context. Chapter 1 deals with the relationship between the migration of South Asian doctors, the development of general practice and the establishment of the NHS. It outlines my argument concerning their role in underpinning what came to be seen as a 'cornerstone' of the British healthcare system. Chapter 2 relates this history to the history of the British presence in the Indian subcontinent and situates it in relation to post-war immigration to the UK.

The second part of the book shows how imperial legacies and professional discrimination were central dimensions of the development

of general practice. Chapter 3 draws on the narratives of South Asian doctors to bring to the fore the persistence of a deep-seated connection with the former metropole which is relevant to our understanding of the movement of doctors to Britain. Chapter 4 looks at the role of professional discrimination in shaping doctors' professional trajectories. Chapter 5 outlines how the limited choices available to doctors in a discriminatory environment led to them having a significant structural effect on the staffing and development of British general practice.

The third part of this book (Chapters 6–8) examines the impact that this group of migrants had on British society and medicine once they had taken up posts as GPs. Chapter 6 reflects on the nature of the relationships that doctors developed with their patients, be they white working class, South Asian or members of other ethnic minority groups. Chapter 7 charts the influence that South Asian doctors had on British medicine as a whole through individual and collective initiatives—such as for instance the establishment of the Overseas Doctors' Association. Chapter 8 focuses more specifically on their impact on the nascent specialty of general practice. In my conclusion, I explore how this history might inform contemporary thinking about the role of migrants in medicine and in wider British society.

Notes

1 It is recognised that the term 'South Asian' does not do justice to the diversity of the group of people it encompasses. It is also the product of a contemporary framework of analysis rather than a reflection of the language used at the time. It is used here in the interests of clarity and simplicity to designate people born in present-day India, Pakistan, Bangladesh and Sri Lanka. It should hopefully be apparent by the end of this book that the shared professional experiences and comparable roles that medical migrants from the Indian subcontinent had in the NHS justify the collective approach adopted in this study. The term 'Asian', which appears at times in interviews with participants and references to other sources, is synonymous in the UK.

2 P. S. Gill, 'General practitioners, ethnic diversity and racism', in N. Coker (ed.), *Racism in Medicine: An Agenda for Change* (London: King's Fund Publishing, 2001), pp. 107, 111. The figure given by Gill is of 4,366

unrestricted GP principals. The expression refers to doctors who provide a full range of general medical services and whose list is not limited to a particular type of person. It excludes some GPs, for instance GP assistants, and salaried GPs. It is indicative of the prominent role that South Asian doctors took on in the GP workforce but does not tell us exactly how many of them worked in general practice at the time.

3 Gill, 'General practitioners'.

4 This estimate is calculated on the basis that the average GP patient list at the time was approximately 2,200 (British Medical Association Archives, London (henceforth, BMA), Executive Committee of Council, 1978–1979, Report of a working party on medical manpower, staffing and training requirements, 9 May 1979). Again, this figure is indicative. It is possible that South Asian doctors had smaller patient lists although given that they were generally to be found working in areas of high demand with an under-supply of doctors the reverse is more likely.

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18 Noiriel, *Le Creuset Français*, p. 19; Simpson et al., 'Writing migrants'.
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