

“Without racism there would be no geriatrics”: South Asian Overseas-Trained Doctors and the Development of Geriatric Medicine in the United Kingdom, 1950–2000

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There has been a long history of migration of doctors from the colonies to the United Kingdom. Records of medical migration show that the practice of moving in order to study in the United Kingdom began at least in the 1840s and kept pace throughout the nineteenth and twentieth centuries, and South Asians¹ accounted for a significant part of this migration.² Those who taught medicine in India, Pakistan, Bangladesh, and Sri Lanka had often trained in the United Kingdom for some time. As a result, many doctors in South Asia felt that they were part of a community of medical practitioners for whom some markers of participation in the U.K. labour market were central to career progression. They had often been advised by their teachers to get training in the United Kingdom.³ Upgrading and validating skills through training at one of the U.K. royal colleges was therefore seen as crucial to being recognized as a good doctor and was embedded in South Asian doctors' professional cultures. Organizations like the royal colleges implicitly shaped migration (and indeed directly benefit financially from it) through their ability to award internationally accredited professional qualifications that were prestigious across the Commonwealth. As a result, many doctors in South Asia were already in some way part of a professional community where migration to the United Kingdom was seen as part of career progression. The South Asian doctors were not alone, of course. The history of colonialism and postcolonialism meant that doctors from other parts of the British Empire and Commonwealth were similarly leaving home to gain qualifications in the

United Kingdom's medical system, though with different experiences and outcomes, as Armstrong's research shows.⁴

This long history of medical migration to the United Kingdom is relatively well known. However, until recently the story of the contribution of South Asian doctors to specific fields has been less discussed. In this chapter we address this gap by focusing on the contributions of migrant doctors to the geriatric specialty. We begin with a history of geriatrics in the United Kingdom and go on to outline our methodology before describing the process by which South Asian doctors came to be working in geriatric medicine, what barriers they encountered, and how networks worked both for and against them, before concluding with a consideration of how certain regional centres of excellence played a part in their professional development and careers as consultants in the specialty.

The History of Geriatrics in the United Kingdom

Since its inception, geriatric medicine had been a "Cinderella specialty," its image affected by ageist attitudes towards the patient group, older people, and its appeal limited among medical practitioners by lack of access to acute beds and thus to private practice.⁵ These are general characteristics, shared by the specialty internationally. However, developments in the United Kingdom, which proved to be pioneering, owed much to the historical coincidence of two factors: early recognition of the possibility that some conditions in old age were recuperable and the inception of a socialized medical service in 1948. The emergence of a clinical medicine of old age had begun in France with Charcot in the nineteenth century and the recognition that, despite their age, many people presumed incurable could be treated and that, in late life, illnesses may have symptoms specific to the aged body.⁶ These ideas were quickly taken up by medical researchers, rather than in therapeutic contexts. It was their application in the latter by Dr Marjory Warren, working in a Poor Law infirmary, the West Middlesex Hospital, in the mid-1930s that would lead to the creation of the specialty. As Grimley Evans argues, "Ignatz Nascher invented the word, Marjory Warren created the specialty; directly and indirectly, her work inspired the development of geriatrics in many countries of the world."⁷ Typically, the chronic sick and older people were not considered capable of rehabilitation or treatment and were housed together in inaccessible buildings and wards. Older people's care was relegated to back spaces,

the backs of buildings, small cottage hospitals, tuberculosis and isolation hospitals, former Poor Law infirmaries and workhouses, and the "back wards" of municipal hospitals. Doctors were rare visitors, and nurses, though caring, rarely fully qualified. Lord Amulree, an early proponent of improved medical care and treatment of older people, wrote in 1951,

A large number of patients were in bed for social and not for medical reasons. Some had been admitted for some forgotten acute or semi-acute condition and had remained ... long after this was cured. Some had been admitted because their relatives, in many cases at work themselves, had found the care of an elderly relative burdensome, and for others there seemed no valid reason why they should be occupying a hospital bed. Many were kept in bed for no better reason than that it was easier for the nursing staff and administration to keep them in bed. Sometimes there was a suspicion that patients were kept in bed because the wards looked tidier that way. Because of this outlook, there was an atmosphere of apathy in the wards that was almost frightening; the patients lay almost like so many animals, with nothing to amuse or interest them.⁸

Marjory Warren devised a system of classification, which depended on the recognition that certain conditions, if not curable, could at least be treated, and in some cases rehabilitation followed. Her aim was to "make a case for their treatment in a special block in a general hospital" so that geriatric medicine might become part of the curriculum of medical students and nurses, improving the care and treatment of chronically sick older people and encouraging research into "the diseases of old age."⁹

Applying these principles to the 714 chronically ill patients, not all old, in the wards for which she was responsible, she was able to reduce the number of beds occupied by people with chronic conditions to 240, at the same time increasing bed turnover to three times the previous rate. Her approach depended on the treatment of older people being recognized as a part of medicine, with teams of trained staff working with professionals in the community, including general practitioners, nurses, and other services.¹⁰ Once published, her results were quickly recognized and taken up by others working in hospitals that, during the Second World War, had come under national direction. However it was to be the arrival of the National Health Service in 1948 and the consequent absorption of so many chronic wards and their patients into a system struggling to manage resources economically and fairly that

would secure recognition of the geriatric specialty.¹¹ Pioneering work, following Warren's example, proved successful in other centres around the United Kingdom. Among geriatricians there were to be divisions over the emphasis given to cure and to long-term care; however, results that freed up beds and created shorter waiting lists meant that the specialty had support in the highest places, with the result that over sixty geriatric units, often in poorly resourced accommodation, were set up from the late 1950s, led by a new cadre of consultants with specialist knowledge in the illnesses of old age.¹² Organization and leadership for geriatricians came with the founding of the Medical Society for the Care of the Elderly in 1947, instigated by Marjory Warren and with the support of early geriatricians, including Lord Amulree. This became the British Geriatrics Society in 1959.¹³

Development in the United Kingdom was very much in contrast with elsewhere in anglophone and other European countries. Though the science of the medicine of old age took off in mid-twentieth century, the development of new care arrangements would be much slower and patchy. In the United States, centres of excellence such as Mount Sinai Medical School and the Jewish Home and Hospital for the Aged, though set up in the context of increased governmental awareness of the need for greater medical research into the illnesses of late life and appropriate clinical interventions, depended on private funding. The Department of Veterans Affairs, with a remit to provide effective care to a more general population,¹⁴ would lead in training and awareness of geriatric medicine that approached the more comprehensive model emerging in the United Kingdom from the mid-twentieth century. In Canada the picture was very similar, with research centres emerging in the 1950s in most provinces, and the Department of Veterans Affairs providing leadership for assessment and rehabilitation, together with comprehensive assessments for older patients. Though the federal Liberal government at the time was committed to health-care programs that would provide financial support, older people would take their place in the queue. A spur to development of trained physicians in geriatric medicine was, Hogan argues, the fact that "about a quarter of its [Canada's] physicians [had] trained outside the country ... in locales where geriatrics was an acceptable specialty." He suggested that in the role of "the stranger," with the accompanying "mobility, objectivity and freedom from convention ... the outside expert can play an important role in the establishment of a specialty." And so it was, for example, in Canada where, during the 1970s,

British geriatricians were recruited to develop health services for older people and in return Canadian physicians travelled to the United Kingdom to train in geriatrics.¹⁵

One element missing from this account is how the geriatric specialty in the United Kingdom was enabled to grow. As we have seen, care and treatment of older people was not highly regarded within the medical profession, and although funding of consultancies would provide leadership and a degree of acknowledgment among peers, growth would be needed in the lower ranks if movement of patients was to be achieved. Histories of the development of the specialty tell us very little about how it was peopled, though there were clues. During 1991, Professor Margot Jefferys and colleagues embarked on an oral history of those she describes as “survivors of the earliest cohort of geriatric consultants.”¹⁶ While carrying out final checks for a chapter she was writing,¹⁷ it became evident that there recurring references in the transcript summaries suggested another presence among the first generation of geriatric specialists. Reading through the transcripts, these pioneers talked about their junior doctors: “Some of my Indians were very good indeed.”¹⁸ “When I came we had an establishment of three house officers ... They were always Asian.”¹⁹ “I had an Indian registrar and an Indian houseman. And actually, some of these chaps were quite good.”²⁰ “There weren’t all that number of British people about but there were some very good Indians.”²¹ Jefferys interviewed only one South Asian doctor who was quite clear about the development of the specialty: “The local boys wouldn’t touch it with a barge pole. So, in effect, geriatrics owes its origin and its beginning to the pioneers who had the vision and the junior doctors from the Indian subcontinent – as simple as that.”²²

Of course geriatric medicine was not the only area of the U.K. NHS to benefit from the contribution of migrant doctors from the subcontinent, as Simpson, Snow, and Esmail in this volume show. What interested us was the combination of two minoritized populations: overseas-trained South Asian doctors and older patients. How and why had the two been brought together appeared to be an interesting question for research. Given that the presence and contribution of this group of doctors was not documented in the history of the specialty, gathering accounts directly from them offered a possible approach. This would have the added advantage of following Jefferys’s example. In the following section we outline the research design that followed when a bid for funding proved successful.²³

Methodology

The seventy-two interviews that Jefferys and colleagues carried out in 1991 with the founders of the geriatric specialty would be followed by a second set of oral history interviews with sixty South Asian overseas-trained doctors (SAG interviewees). The two set of interviews would cover the history of developments in the health care of older people from the late 1930s. This second set of data was recruited through networks of overseas doctors (the British Association of Physicians of Indian Origin, for example), the British Geriatrics Society, and snowballing. Interviews cover the period from 1950 to 2000. The two data sets thus reflect slightly different, albeit overlapping, periods in the history of geriatrics, the emergence of the discipline in some centres, and the adoption and adaptation of practices as they radiated from these centres across the country. Hence, the South Asians operated in a framework where there was some national infrastructure for advancing geriatrics but faced issues similar to those interviewed by Jefferys, as up to the mid-1980s both were operating in areas that had very little local infrastructure and accorded geriatrics with little status.²⁴ Both sets of interviewees use a life history approach, asking participants to talk about their life from childhood to the present. Areas of interest included the development of services and the progression of careers during fluctuations in the supply of and demand for doctors.

The SAG interviewees included doctors trained in India, Bangladesh, Sri Lanka, Pakistan, and Burma, ranging in age between forty and ninety-one and arriving in the United Kingdom from the early 1950s onwards. Almost all of these interviewees work(ed) as consultants, and some also held academic posts. We focused primarily on the period between the late 1960s and late 1980s, when the issues of the time often resonated with many today: anxieties about an aging population;²⁵ a highly politicized environment around issues of migration and race, as evidenced by the Commonwealth Immigrants Acts (1962, 1968) and the Immigration Act (1971).²⁶ Debates and legislation led to change in the meaning of race. Together with concerns over the management and future of the NHS,²⁷ this meant that the habitus within which social networks, recruitment practices, and career progression operated was altered.

The choice of oral history as a method is well-attested. It offers the possibility of locating the migration experience within the longer trajectory of a life history, contextualizing migration as one of many events

that shapes individual lives. It is produced in a dialogue that encourages narration and reflection and thus provides evidence of subjective lived experiences.²⁸ Comparing two different data sets has produced its own richness, revealing hidden links in the experiences of both groups²⁹ and providing evidence on the ways in which opportunity may be fashioned and created under conditions of adversity and perversity.³⁰

The oral history interviews have been supplemented by archival research. The archives of the Department of Health, the British Geriatric Society (BGS), British Medical Association, Royal College of Physicians, Royal Society of Medicine, and the papers of organizations such as the Overseas Doctors Association have all been consulted to understand the issues facing doctors working in the specialty in the second half of the twentieth century.

South Asian Doctors and the Geriatric Specialty

As we have seen, from its inception the NHS has depended on recruiting staff from overseas. This migration was part of a long-standing tradition of movement between South Asia and the United Kingdom. Development of a medical career often involved experience of overseas work so that movement across the Commonwealth countries, and especially to and from the United Kingdom and the colonies, was part of colonial history. Moreover, the reach of Western medicine was made possible only by this mobility, as its spatial claims rested on movement, learning medicine from these Western centres and reproduction of its practices in centres around the world.³¹ Hence, U.K.-trained doctors moved to countries like India, while Indian doctors moved to the United Kingdom to learn and to be trained.³² Migrant doctors were necessary for the operation of the health service, as they provided a mobile army of labour in the lower rungs of the medical hierarchy. However, once in the United Kingdom, they were systematically disadvantaged in access to jobs, career mobility, the places where they found employment and the specialties they could occupy.³³ These doctors were ethnically marked through their race and their countries of qualification.³⁴ The fact that in 2003 only 17 per cent of South Asian doctors were consultants compared with 42 per cent of white doctors³⁵ provides some evidence that migrant doctors from South Asia found their careers limited by the institutionally racist and hierarchical nature of the NHS.³⁶

For instance, migrant doctors found that, despite the internationalization of the education they had received in South Asia and the

dependence of the United Kingdom's NHS on migrant doctors, this international professional community had a preference for local graduates built into it that would direct their careers in ways that they had not expected. Barriers based in traditions of assumed superiority or straightforward prejudice might present substantial impediments to mobility inside the United Kingdom. Letters of reference written by doctors who had trained in the United Kingdom but had returned to South Asia were not considered adequate for a substantive post, as one interviewee found: "No. I always had a job. I've never ... only when I first came, for the first two weeks I didn't have a job. The first two weeks I was getting acclimatised, wondering what to do, then my brother found this. And I sent job applications with my reference from consultant and so on and didn't work at all, you know, when I first came. I sent lots of applications with copies of my glowing reference from my consultant in Sri Lanka. Didn't help at all."³⁷

They also found themselves channelled into the less popular specialties like geriatrics, as another interviewee recalled:

And he said, "I'll show you something then." So there was a job in Newcastle coming up, applying for cardiology consultant job, you see. And he showed me the applicants, you see, because he was on the interview panel for that consultancy. So guy from Edinburgh, a guy from Cambridge, a guy from Oxford, one guy coming from Canada, one coming from New Zealand, one coming from London, from Brompton. And he said, "Have a look at their names as well. They are all local graduates." So he said, "Where do you fit in there? Do you think you have any chance there?" [Laughs] So I said, "Probably not," so he said, "Well my advice to you, forget about it, because you could be wasting for time by doing cardiology."³⁸

As Simpson, Snow, and Esmail show in this volume, doctors who became general practitioners encountered similar prejudice and obstacles, deflecting them from their original and preferred area of medical work.³⁹

The quotation included in the title of our chapter succinctly describes the outcome for the geriatric specialty. Disinterest among U.K.-born graduates in working with older patients⁴⁰ led to opportunity for South Asian graduates. In geriatrics from the 1960s, as the early geriatricians sought to build departments, a crisis of staffing from 1960s meant that it was difficult to fill posts using a U.K.-trained cohort. As a result the new specialty depended on overseas-trained doctors for its existence and growth. By 1974, 31 per cent of consultant geriatric posts and

60 per cent of registrar posts were filled by overseas-trained graduates, the figures having risen from 15 and 33 per cent respectively in 1967.⁴¹ A survey found that 40 per cent of geriatricians who were appointed as consultants in England in 1981–2 were overseas graduates.⁴² These doctors built up a specialty at a crucial time in the history of the discipline. Migrant doctors were encouraged, with commitment that varied from whole-hearted support to a distance bordering on discrimination by senior staff, as the quotations from the Jefferys interviews illustrate, keen to build the specialty and change to practices that offered rehabilitation rather than incarceration.

Interestingly, geriatrics had offered similar opportunities to some founders of the specialty. Among those interviewed by Jefferys were several who, for a variety of reasons – including disruption to their training due to wartime service, refugee status, or wrong choices – rose to prominence in the early years of geriatric medicine.⁴³ The phrase “falling off the ladder” tends to recur in the Jefferys interviews as they describe their careers. Dr Marion Hildick-Smith recalls that when she wanted to return to work after a childcare break, going down a few rungs could be advantageous to someone hoping to progress:

There was the beginning of a plan to attract married women back, because I think they felt they were perhaps wasting a lot of potentially helpful people. And so I said, “What about the possibility of coming back and training in geriatrics?” The comment from the regional officer at that time was, “What on earth would you want to do that for?” So it was not really immediately taken up with enthusiasm ... I applied for and got a registrar post in geriatric medicine, part time, with the possibility that it might become a senior registrar post. There was no guarantee and it was a bit of a gamble, because really it was going down a couple of grades, but I felt it was worth doing that in order to try and get restarted on the medical ladder.⁴⁴

Gaining Access to a U.K. Medical Specialty

Though the specialty offered opportunity to those prepared to take it up, and who were also prepared to work hard to prove their worth, progress was not automatic. Networks still mattered, and the geography of access was also a determinant. In what follows we consider two aspects of medical networks – their international and professional limits – before going on to look at where South Asian doctors found opportunity in the NHS.

Networks and Their Limits

As we saw earlier, migrant doctors who had expected that recommendations from teaching staff in their medical colleges would ease their entry into the U.K. medical profession and its most desirable specialties were, with few exceptions, disappointed. Geriatrics was considered to be the “crumbs” that people went into, not out of choice but because of the compulsions of exclusion from more desirable specialties, as one interviewee stated: “Initially I think people went in not out of choice. It was almost out of compulsion because you were here, you didn’t have a job, etc. So we were given the crumbs basically. Whatever was left at the ... you know.”⁴⁵

Rejection of job opportunities in geriatrics by white, U.K.-trained medical trainees meant that South Asians, who found few other opportunities, came to dominate geriatrics. It therefore came to be known as the “curry” department and to be held in disdain, especially by those who worked in teaching hospitals. One interviewee talked about how Sunderland, a general hospital that became a centre for geriatric development, was viewed by doctors visiting from the teaching hospital in neighbouring Newcastle-upon-Tyne in the northeast of England:

Yes, Newcastle University. Because we always had senior registrar from here. We used to have medical students coming from there all the time. So we never had any problem. It was different matter if we find the oddball registrar coming over here and talk to the university: “Oh it’s a curry department at Sunderland. Why do you want to send me there?”
[laughs]

Is that what they call it?

Well one of them did. He went to professor, he said, “Oh it’s a curry department” [laughs].⁴⁶

The interviewee speaks about how visits to Sunderland were related back at Newcastle, where white doctors were more dominant.

So how did South Asian doctors come to be over-represented in geriatrics? And what forms did this participation in the speciality take? There were a number of ways in which their paths tended to be directed, and throughout the interviews the selective usefulness of networks was iterated.

Gaining access was determined in part by using migrants' own networks of support and communication and the transnational social capital of family members (as we saw earlier), but, more commonly, members of college alumni. These networks were adequate for short-term locum posts (covering for absent doctors) and clinical attachments. But it was the structure of the medical labour market – abundant availability of short-term, temporary posts – that allowed these networks to be effective.⁴⁷ As one doctor said, the hospital authorities would not advertise for such locum posts but would use references from staff: “‘My God we want a locum doctor. Do you say that’s a nice Sri Lankan doctor and he says he’s good? We can take his word for it.’ And they appointed.”

However, there were limits to these introductions, as non-migrants' own networks took precedence over those of the migrants.

And CV, none of that helped then?

No, no. I suppose I didn't really try hard enough, I think because I thought the thing is to get a job and get some money. Close to a place where I could still come to my brother's place. Yeah. So I think once you get a good reference, then it's good. But patronage definitely helps, because I've certainly seen British people doing it too. They know somebody who knows somebody and they are ... it's more difficult now, it's more fair actually now. Patronage doesn't help that.⁴⁸

Patronage was clearly an important route into the career of non-migrants. Limited access to the social networks of non-migrants meant that those networks often worked against migrants.⁴⁹ In order to be successful, migrant doctors had to learn to utilize and benefit from selective incorporation into these non-migrant networks. Forms of patronage selectively opened up job opportunities for migrant doctors' entry into paths offering career progression. As was frequently the case, for one interviewee the first locum was arranged through contacts with other South Asians, while the more substantive post depended on contacts with, and entry into, non-migrant networks. “‘So he said ‘No, no. There is a locum post has come up for you in Glasgow. You take it.’ He said it is for me, but you will not get any job otherwise. [laughs] So I took the job. Locum for six weeks. Once I got the job, that's it. They want me all the time there. You won't believe it, because that is the job, senior house officer in respiratory medicine, a bit of elderly care.”

Finding Opportunities in the NHS

Once in post, access might be achieved and maintained by working long hours and displaying high levels of commitment to patients and the specialty:

In that post I spent most of the time in the ward looking after the patients. Being totally committed to the patients and teaching ... And so one day one of the consultants turned up at about six thirty, seven in the evening, and he saw me still doing the round, and said, "What are you doing there?"

"I'm finishing my patients. Still there are two more left."

He said, "You are too dedicated," ... and the next year recommended me for a senior registrarship post to the professor.⁵⁰

However, the places in which South Asian geriatricians found jobs also reflected exclusion – not merely from desirable specialities but also from many of the infrastructures of modern medicine, such as new buildings:

One thing was disappointing that care of ... geriatric medicine and care of the elderly was not given enough, you know, importance. We were not part of the district general hospital. We were about a mile away in a workhouse. And I think we were very well organized. From day one I liked the speciality, because you could see teamwork and, you know, multidisciplinary team-working. It changed my whole way of thinking what medicine's about. But definitely we were not given the right, you know. We were seen as second-class citizens within the NHS.

In what ways were you seen as second class?

Like I said, we were not part of the district general hospital, separate hospital. That was brand new hospital. We were in a workhouse. Here we went for clinical meetings, you know, we just felt as if we were not at the same level as the others. Generally you would find that these jobs were all for people from my part of the world, while all the other local graduates were getting jobs in those sort of general medical posts, etc.⁵¹

South Asian doctors also largely found their opportunities in hospitals with fewer facilities and areas that U.K.-qualified graduates avoided: "First of all, in the initial days they filled the jobs when nobody else would take it. And they tried to copy the best leaders, and implement changes in their own patch like the best leaders had done. So there were geriatricians in hospitals where facilities were so poor I

probably wouldn't work in those even today. And so that's one of the things that they went to the areas where local doctors didn't go. And they filled those jobs where local doctors weren't interested. It wasn't that the local doctors didn't get those jobs. They weren't interested in those jobs."⁵²

Overseas qualified doctors also found it easier to get posts in provincial district general hospitals, rather than in major metropolises or teaching hospitals.

Why do you think there's so many South Asian doctors went into geriatrics?

... One should recognise it actually, that that was a specialty where the local graduates were not attracted to at that time because it was not very attractive to go to. So it was easier to get, probably to become a consultant actually, yes. But then places like King's College or Greenwich – not easy. It was not easy there, ok. So in provincial hospitals it was probably easier.⁵³

However, these "provincial hospitals" were less likely to offer training, and most doctors found themselves on short-term contracts, moving around the non-metropolitan areas, until they found a sympathetic consultant who would take them on in a post where they could expect to be able to study for their membership in the Royal College of Physicians. Even in geriatrics where the pressure was on to build departments, access could be difficult, as some found: "He liked people from overseas very much. There were people ... how I should put it? They may not ... couldn't care less. For example, I met one professor, I described earlier on, in Liverpool [he mentions an example of direct discrimination]. There's another one, he was in Birmingham ... I went to see him while I was in Birmingham. He gave me ten minutes of his time and said, 'Could you see my secretary after that?' And that was the end of it. Not everybody likes foreign doctors."⁵⁴

Opportunities to progress thus depended on a combination of structural constraints that worked both against and for the migrant doctors. Barriers rooted in racist attitudes and discriminatory practice foreclosed career development and satisfaction for overseas doctors, who were clearly not "local." A frequent comment was that in the mid-1970s the consultants would say "I have shortlisted. This is my shortlist. I have included all those that I could ... the names I could pronounce and spell."⁵⁵ Stories of these barriers to entry in more desirable specialties were echoed by almost all our interviewees. Perversely, as we have shown, the marginalization of geriatric medicine meant that promotion

up the ladder became possible, even if it meant that hopes for success in other specialties such as cardiology or surgery had to be given up. Importantly, it also gave doctors opportunities to contribute to developing a growing discipline to shape it through rearranging the spaces of care, learning and disseminating how to care better, and thus institutionalizing a set of care practices across the United Kingdom.

Creating spaces where learning could happen meant taking chances for migrant doctors seeking their way in the specialty. This could be future-oriented risk-taking but it offered personal and professional opportunities for change, which could also provide something new to local populations. From such centres, whether or not they were attached to teaching hospitals, teaching and learning – for junior doctors, nurses, and general practitioners – could be developed, and substantive evidence for the efficacy of the specialty's approach became evident, as we explore in the next section.

Establishing Geriatrics / Becoming Established in Geriatrics

The South Asian doctors we interviewed embedded themselves within geriatric medicine and the NHS often by becoming attached to senior doctors at centres where there was innovative and successful practice. Then, as we show, they began to set up their own centres.

Establishing Geriatrics and the Role of Centres of Learning

As we saw earlier, geriatrics came to be established in centres away from teaching hospitals in the big cities where services were so poor that these disregarded spaces required and offered the most opportunities for innovation. Thus Sunderland, rather than the teaching hospital in Newcastle, became the centre of excellence in geriatric practice, for several reasons. In Sunderland

the snooty hospital was the old voluntary hospital, so the Royal Infirmary was where all the nice people were doctors and the nice people were patients. The less nice doctors were in the old municipal hospital and the less nice patients were there too.

But as so often happened – it happened in Southampton as well – the municipal hospitals were endowed with much bigger grounds, so that when massive expansion came, it largely couldn't be in the old voluntary hospitals, because they outstripped the envelope size and

quickly outstripped the site size too. So that eventually, when the major rebuild of hospitals took place in Sunderland, it was on the general hospital site rather than on the restricted Royal Infirmary site. Anyhow, Oscar Olbrich – this is in the 1940s–1950s, soon post-war – developed a research unit there. He developed an acute admissions unit. He had recruited good remedial therapy staff and social work staff and that sort of thing and had persuaded the hospital management committee – probably Jack Cohen was the chairman of that – and the Newcastle Regional Hospital Board – they still had a board in those days – to fund lots of medical posts, so it was a relatively well-staffed unit.⁵⁶

Their physical location, the backing of individuals such as Jack Cohen and the Labour town council, and most importantly the leadership of individuals who innovated their practices and established new ways and norms for the care of older people was paramount in establishing these centres of excellence. As we see in the extract above, the practice in Sunderland was led initially by Oscar Olbrich, a refugee from Vienna who had wanted to do nephrology in Edinburgh but, being a refugee and not an Edinburgh graduate, he realized that he had little chance of being appointed as a consultant there and therefore moved to Sunderland. Olbrich, along with his assistant, Dr Eluned Woodford Williams, developed geriatrics through the 1950s, and Sunderland was then ably led by Williams for a number of years, providing opportunities for several of our SAG interviewees.⁵⁷ Sunderland was one of the first places to use age-related admissions policy – admitting all patients over a particular age, in this case sixty-five – into a ward, irrespective of their ailments. This practice was based on the recognition of, and the desire to, care for the special needs of an age cohort. Dr Brown, while talking about the work of Dr Olbrich, argued that this care was underlain by “elementary principles which is ‘Just give the same standard of care to old people as you give to others.’”⁵⁸ This practice was subsequently adopted and adapted in centres by many who passed through Sunderland.

These centres of good practice were not only claiming excellence in care but were also significant in development of geriatrics in the United Kingdom. But in the words of Philip Hutton, “How much these ‘pockets’ were just pockets of development and how long it took for other places to catch up is a question.”⁵⁹ Hence, the spread of practices depended on people passing through these centres, which soon became reified as centres of learning, through which those in the learning stages

of the medical career hierarchy (especially as registrars and senior registrars) had to pass to claim knowledge. As one SAG interviewee recalled, having been through a centre of learning clearly gave him an edge and shaped his career decisions:

If I were to make a career in U.K., geriatric medicine was perhaps a better career for me, especially being trained in Sunderland. But again, as I said, the career progression was so rapid in Sunderland that, you know, I just rode with it ...

And how did you feel about going into geriatric medicine then?

No problem, because what I was seeing the geriatric medicine there was very appealing branch, because we had ... funnily enough we also had a first special dedicated six-bed ward for MI [myocardial infarction] care in Sunderland.⁶⁰

Passing through these centres gave geriatric trainees pride in their field and a form of capital that they could use to develop their careers elsewhere. Association with such centres of learning thus shaped career trajectories.

However, the success of centres such as Sunderland was also related to the ways in which those who passed through them extended its reach by following practices they had learned there. They were not about individual learning but about embedding good practice as a model for policy development. "Models, in this sense, do not simply designate place-specific processes of innovation or sites of creative invention, as the diffusionist paradigm might have it; they connote networks of policymaking sites, linked by overlapping ideological orientations, shared aspirations, and at least partly congruent political projects."⁶¹ In effect this bundling of good practice laid the basis for solving a set of policy problems that were extant throughout the United Kingdom during that period.

Becoming Established in Geriatrics and Building Their Own Centres

Geriatricians who passed through Sunderland also made choices about where they might have the most impact and where they might have the most chance to adopt and adapt these innovations when making decisions about their career. As one SAG interviewee remembered,

I found out that the unit is very well developed, nothing I can do. Then I had other interview I didn't go, then I came to Rotherham one, in between

I'd got, Harrogate, which I refused because I came to know that it's not I, my consultant Pengelly wants Harrogate, because he like Harrogate, posh area you see. I don't want to go posh area. Then I came to Rotherham and looked at the unit. Nothing was here. Blank sheet, in Rotherham, nothing, no junior staff, lots of beds, no geriatric, nothing, no services, lot of patient here long stay.⁶²

He recognized the potential that the "blank sheet" gave him to practise the learning he had acquired in Sunderland. It would allow him to set his own mark. As such, professional growth, it appears, was intimately tied to practising innovation in new territories and spaces, thus extending the reach of these forms of innovation. It offered a way of forwarding their field.

Finally, as the speciality became more established, these stories of entering geriatrics for lack of choice become tempered by stories of how people chose geriatrics as a discipline:

And what was it that you particularly liked about geriatrics?

Because it was still general medicine, a lot of ... and you could do a lot of specialities within the speciality itself, but also the multidisciplinary working, because I'd never seen it before and I thought it was wonderful it worked.

And was there anything particularly distinctive about the ways in which geriatric medicine was practised in that hospital?

Yeah, in the hospital where I worked, where I worked as an SHO [senior house officer] the geriatrics was very high profile. And we had some really great geriatricians in it who were both academically brilliant but had a lot of national standing and ...made geriatrics look a very attractive speciality.⁶³

Migrant doctors thus became not only the workhorses of the new speciality as it developed, away from the main teaching hospitals and centres, in the district hospitals in north and south Wales, the Northwest, Midlands, and Northeast of England but the leaders also set out an agenda on how new departments should expand and teach.

Conclusion

In this chapter we have focused on the development of a speciality in one of the less desirable specialties, geriatrics, within the United

Kingdom's National Health Service. This in many ways echoed the status of migrant doctors who too were marginalized within the NHS. From the 1960s through to the 1980s this migration was dominated by South Asians who came to the United Kingdom to obtain training, as working there had been considered part of the natural career progression for many doctors in the Commonwealth. Shortages of home-grown doctors and the historical relationship between the United Kingdom and its former colonies meant that the NHS attracted and depended on the skills and commitment of overseas-trained staff.

"Without racism there would be no geriatrics" tells the story from the perspective of those doctors. Once in the United Kingdom they found that, although South Asians considered themselves a part of the same medical fraternity, the references the migrant doctors obtained from their home countries rarely carried weight. Instead they initially found access to jobs through their compatriots who were already working in the NHS. Access to more substantive posts, however, depended on being able to access patronage networks of non-migrant doctors. This was more easily done in some specialities where there were few non-migrant doctors, either because of the nature of the speciality or because of the places where they were practised. One such area in which migrant doctors found opportunities to progress in their career and where they benefited from the push to expand and develop services was in the care of older people. In doing so they also played a central role in its development. Interviews by Margot Jefferys with those who originally set up the geriatric specialty in the early years of the NHS, followed up by our interviews with South Asian overseas-trained doctors demonstrate how, to grow and become established, the geriatric specialty depended on migrant doctors. Thus a marginalized group of doctors were brought into contact with marginalized patients.

Individual interviews enabled us to go beyond counting heads to establish a spoken presence, over time, which we argue has had a direct impact on health debates. A recurring theme is the extent to which the South Asian doctors we interviewed were not only providing a service but were innovating and taking the practices they had learnt in the centres of excellence beyond the selected pockets of development. The doctors were in part able to overcome the history of racism in the NHS that had led them to be in the speciality of geriatrics by adopting and adapting a career in this speciality. They thus helped to advance the discipline, although this is a story that is not widely recounted in the history of the discipline. Specifically, our study of migrant doctors and

their role in the emergence and establishing of the geriatric specialty demonstrates an aspect of health policy that is still of great concern today. In an era where concern over the future health needs of older members of society is pressing, recognition for what may be learned from the experiences and commitments of migrant doctors is crucial.

NOTES

- 1 Throughout we use the term *South Asian* to refer to people from countries in the southernmost tip of the Asian continent, from Afghanistan to Sri Lanka and including Burma, Nepal, Bhutan, and the islands of the Indian Ocean. In so doing we are following the practice of the World Bank and common usage in the United Kingdom.
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- 6 Stephen Katz, *Disciplining Old Age: the Formation of Gerontological Knowledge* (Charlottesville: University Press of Virginia, 1996).
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- 9 M. Warren, “Care of Chronic Sick: A Case for Treating Chronic Sick in Blocks in a General Hospital,” *British Medical Journal* 2, no. 4329 (25 December 1943): 822–3.

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- 12 Susan Pickard, "The Role of Governmentality in the Establishment, Maintenance and Demise of Professional Jurisdictions: The Case of Geriatric Medicine," *Sociology of Health and Illness* 32, no. 7 (2010): 1072–86; Denham, "History of Geriatric Medicine."
- 13 G.F. Adams, "Eld Health: Origins and Destiny of British Geriatrics," *Age and Ageing* 4, no. 2 (May 1975): 65–8.
- 14 John E. Morley, "A Brief History of Geriatrics," *Journals of Gerontology*, ser. A, 59, no. 11 (2004): 1132–52; Lissy Jarvik, "Commentary: A Brief History of Geriatrics," *Journals of Gerontology*, ser. A, 59, no. 11 (2004): 1162–3.
- 15 David B. Hogan, "History of Geriatrics in Canada," *Canadian Bulletin of Medical History | Bulletin canadien d'histoire de la médecine* 24, no. 1 (2007): 131–50.
- 16 The seventy-three Jefferys interviews are catalogued in the British Library (hereafter BL) Sound Archive with the collection title "Oral History of Geriatrics as a Medical Specialty" (hereafter OHGMS) cat. no. C512, <http://cadensa.bl.uk/uhtbin/cgiisirsi/x/0/0/5?searchdata1=CKEY5040601&library=ALL>.
- 17 Margot Jefferys.
- 18 Dr Morag Insley (born United Kingdom 1924, WHO consultant in geriatric medicine), interviewed by Margot Jefferys, OHGMS, BL cat. no. C512/36/01–02.
- 19 Dr Eric Morton (born United Kingdom 1919, consultant physician in geriatric medicine), interviewed by Margot Jefferys, OHGMS, BL cat. no. C512/4/01–02.
- 20 Dr Richard Benians (born United Kingdom 1906, consultant physician in geriatric medicine), interviewed by Margot Jefferys, OHGMS, BL cat. no. C512/55/01–02.
- 21 Dr Thomas Rudd (born United Kingdom 1906, consultant physician in geriatric medicine), interviewed by Margot Jefferys, OHGMS, BL cat. no. C512/21/01.

- 22 Dr Mohan Kataria Singh (born India 1917, arrived United Kingdom 1947, consultant physician in geriatric medicine), interviewed by Margot Jefferys, OHGMS, BL cat no. C512/50/01.
- 23 ESRC funded project, "Overseas-Trained South Asian Doctors and the Development of Geriatric Medicine," grant reference number RES-062-23-0514, 2007–09. All the interviews have been transcribed and have been deposited at the BL under "Overseas Trained South Asian G – Interviews," cat. no. C1356, <http://cadensa.bl.uk/uhtbin/cgiisirs/x/0/0/5?searchdata1=CKEY7308185&library=ALL>.
- 24 See, for example, Martin Gorsky, "'To Regulate and Confirm Inequality'? A Regional History of Geriatric Hospitals under the English National Health Service, c. 1948–c. 1975," *Ageing and Society* 33, no. 4 (2013): 598–625.
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- 31 Raghuram, Henry, and Bornat, "Ethnic Clustering among South Asian Geriatricians in the UK," 287–96.
- 32 G. Forbes, "Medical Careers and Health Care for Indian Women: Patterns of Control," *Women's History Review* 3, no. 4 (1994): 515–30; M.H. Fisher, *Counterflows to Colonialism: Indian Travellers and Settlers in Britain 1600–1857* (New Delhi: Permanent Black, 2004); Bornat, Raghuram, and Henry, "Revisiting the Archives."

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- 59 Dr Philip Hutton (no DOB given, consultant physician in geriatric medicine), interviewed by Margot Jefferys, OHGMS, BL cat. no. C512/11/01.
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